Female mental health care users' perspectives of their occupational engagement at a tertiary psychiatric facility.

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Declaration

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Abstract

Introduction: The prevalence of mental illness, burden of disease in South Africa is increasingly high, a global trend amongst other low-and middle-income countries, affecting more females than males. Poverty, crime, intimate partner violence and the existence and co-morbidities, such as HIV, make people in previously disadvantage areas, particularly females, more vulnerable to mental illness. South Africa's legislation, and vision for mental health, outlined in Healthcare 2030 exemplified the improvement of tertiary psychiatric services and patient experience, in the face of decentralisation. Despite this, readmission rates remain high, a complex phenomenon, for which the reasons are multifaceted. One of the reasons cited is that the lack of meaningful occupational engagement for patients in mental health care leads to a deterioration of mental health and subsequent relapse and readmission. The aim of the study is to explore female mental health care users' perspectives of their occupational engagement in the pre-discharge ward at a tertiary psychiatric facility.

Methodology: The study is grounded in a constructivist paradigm. A qualitative method of inquiry investigates the subjective underpinnings of meaningful occupational engagement of mental health care users. The collective case study used data from interviews, the Activities Clock, participant observations and the programme in the pre-discharge ward. Five (*n=5)* participants were included in the collective case study. Inductive analysis was used to analyse data. A four phased analytical strategy, thematic, content, within-case and across-case analyses was performed. Credibility was ensured through member checking. Data triangulation was ensured by using multiple data sources. An audit trail and thick descriptions were used to ensure transferability. The findings of the study were verified amongst other researchers in the field, ensuring confirmability. Reflexive journaling was used to bracket the researcher's thoughts and feelings. The study received ethical approval and adhered to sound ethical practices.

Findings: Two themes emerged. The first theme, "*this is not a prison, it's a hospital",* demonstrated mental health care users' experience of dehumanisation in the pre-discharge environment. Mental health care users experienced gross human rights violations in the number of restrictions they were subject to, the lack of privacy and freedom enforced by staff in the pre-discharge ward. The second theme, "*we need to do more"* highlights that mental health care users were unstimulated, bored, and frustrated in the pre-discharge ward. There were not enough opportunities for meaningful occupational engagement in the pre-discharge ward.

Discussion: Tertiary psychiatric facilities situated in the medical model violated the occupational and human rights of mental health care users and creates an environment ill conductive for occupation-based practice. Navigating mental health care users' rights to freedom and privacy, with the responsibility of healthcare providers to offer a safe and caring environment, that is supportive of the recovery of mental health care users in the pre-discharge ward, remains a challenge.

Conclusion: Tertiary psychiatric services should embrace a shift in paradigm from a dominantly medical model towards an occupation-based practice and recovery approach, in an environment that is less restrictive, that creates opportunities for meaningful occupational engagement, within a human and occupational rights framework.

Opsomming

Inleiding: Soos in baie ander lae- en middelinkomstelande wêreldwyd, maak geestesiekte in Suid-Afrika 'n al hoe groter deel uit van die nasionale siektelas. Vroue word erger as mans geraak. Armoede, misdaad, geweld tussen verhoudingsmaats sowel as onderliggende toestande soos MIV maak mense in voorheen benadeelde gebiede, veral vroue, meer kwesbaar vir geestesiekte. Te midde van desentralisasie stel die Suid-Afrikaanse wetgewing en visie vir geestesgesondheid in *Healthcare 2030* 'n verbetering in tersiêre psigiatriese dienste en pasiëntervarings in die vooruitsig. Nietemin bly heropnamesyfers hoog. Die redes vir hierdie komplekse toedrag van sake is uiteenlopend. Een daarvan is die gebrek aan sinvolle aktiwiteitsverbintenis ("occupational engagement") onder gebruikers van geestesgesondheidsorg, wat 'n verswakking in geestesgesondheid en gevolglike insinking en heropname tot gevolg het. Die doel van die studie was om vroulike gebruikers van geestesgesondheidsorg se sienings van hulle aktiwiteitsverbintenis in die voorontslagsaal by 'n tersiêre psigiatriese fasiliteit te ondersoek.

Metodologie: Die studie is binne 'n konstruktivistiese paradigma uitgevoer. 'n Kwalitatiewe navorsingsmetode is gebruik om die subjektiewe elemente van sinvolle aktiwiteitsverbintenis by gebruikers van geestesgesondheidsorg te bestudeer. Die kollektiewe gevallestudie het van data uit onderhoude, die aktiwiteitsklok, deelnemers se waarnemings en die program in die voorontslagsaal gebruik gemaak. Vyf (*n = 5)* deelnemers is by die gevallestudie ingesluit. Data is induktief ontleed. 'n Driefase- analitiese strategie is gevolg, met ontledings volgens tema, per deelnemer sowel as tussen deelnemers. Geloofwaardigheid is verseker deur deelnemerbekragtiging, en datatriangulasie deur die gebruik van veelvuldige databronne. 'n Ouditspoor en ryke beskrywings het oordraagbaarheid verseker. Die bevindinge van die studie is by ander navorsers op die gebied nagegaan, wat bevestigbaarheid verseker het. Die navorser het ook 'n oordenkingsdagboek bygehou om gedagtes en gevoelens op te teken. Die studie het etiekgoedkeuring ontvang en aan alle vereiste etiese praktyke voldoen.

Bevindinge: Twee temas het aan die lig gekom. Die eerste tema, "*Dit is nie 'n tronk nie, dis 'n hospitaal",* het geestesgesondheidsorggebruikers se ervaring van ontmensliking in die voorontslagsaal getoon. Deelnemers het erge menseregteskendings beleef ten opsigte van die getal inperkings en ingekorte privaatheid en vryheid waaraan personeellede in die voorontslagsaal hulle onderwerp het. Die tweede tema, "*Ons moet meer doen"*, het beklemtoon dat geestesgesondheidsorggebruikers in die voorontslagsaal ongestimuleer, verveeld en gefrustreerd gevoel het. Daar was nie genoeg geleenthede vir sinvolle aktiwiteitsverbintenis in dié saal nie.

Bespreking: Tersiêre psigiatriese fasiliteite binne die mediese model blyk die beroepsvryheid en menseregte van geestesgesondheidsorggebruikers te skend, en skep nie ’n bevorderlike omgewing vir aktiwiteitsgebaseerde praktyk nie. Dit bly oënskynlik ’n uitdaging om ’n middeweg te vind tussen geestesgesondheidsorggebruikers se reg op vryheid en privaatheid, en gesondheidsorgverskaffers se verantwoordelikheid om ’n veilige en deernisvolle omgewing te bied wat herstel by persone in die voorontslagsaal ondersteun.

Gevolgtrekking: Tersiêre psigiatriese dienste behoort ’n paradigmaskuif te ondergaan van ’n oorwegend mediese model na ’n benadering van aktiwiteitsgebaseerde praktyk en herstel. Dít behoort te geskied in ’n minder beperkende omgewing, wat geleenthede skep vir sinvolle aktiwiteitsverbintenis binne ’n raamwerk van menseregte en beroepsvryheid.

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Definitions of key terms

- **Basic activities of daily living:** Activities that include taking care of one's own body. These are also known as activities of daily living and personal activities of daily living. These activities are important for living in the world and for survival (American Occupational Therapy Association, 2014).
- **Instrumental activities of daily living:** "Activities to support daily life within the home and community that often require more complex interactions than those used in activities of daily living" (American Occupational Therapy Association, 2014, p.19).
- **Mental health:** "A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2011 (WHO), p.1).
- **Mental Health Care User:** "A person in receipt of care, treatment and rehabilitation services or using health services at a health establishment aimed at enhancing the mental health status of the user" (Mental Health Care Act 17 of 2002, p.6).
- **Occupation:** "Occupation is understood as paid work. Occupational therapists recognize occupation in a broader sense. Occupations include the day-to-day activities that enable people to sustain themselves, to contribute to the life of their family, and to participate in the broader society" (Crepeau, Cohn & Schell, 2003, p. 28).
- **Occupational engagement:** "Participating in meaningful occupation" (Kennedy & Davis, 2017, p.105).
- **Perspective:** "A particular way of viewing things that depends on one's experience and personality" (Cambridge dictionaries online, 2020).
- **Psychosocial rehabilitation:** A holistic, integrated treatment approach to mental illness, situated within a patient-centred framework (Rudnick, 2018).

List of Abbreviations

- **ACT:** Assertive community treatment
- **BADL:** Basic activities of daily living
- **DALY:** Disability-adjusted life years
- **DoH:** Department of Health
- **DSM-V:** Diagnostic Statistical Manual of Mental Disorders Version 5 (American Psychiatric Association, 2013).
- **FAU:** Female Admission Unit
- **HIV:** Human immunodeficiency virus
- **IADL:** Instrumental activities of daily living
- **LGH:** Lentegeur Hospital
- **LMICs:** Low-and middle-income countries
- **MDT:** Multi-disciplinary team
- **MHCA:** Mental Health Care Act 17 of 2002
- **MHCUs:** Mental health care users
- **MO:** Medical Officer
- **MSE:** Mental state examination
- **MTAS:** Master's in occupational therapy technical advisory sessions
- **OT:** Occupational Therapist
- **OPD:** Outpatients department
- **PSR:** Psychosocial rehabilitation
- **PT:** Physiotherapist
- **SASH:** South African Stress and Health study
- **SW:** Social worker

Thesis overview

This thesis delineates six respective chapters. In each chapter, as far as is possible, concepts and research processes are further explicated by an illustration. The introduction details the background, research problem and research purpose. Chapter two presents a comprehensive literature review in the field and outlines the research aims and objectives. Chapter three elucidates the research paradigm, approach, study design, and evaluates the research quality. Chapter four details and presents the findings, tabulates the themes and categories, and offers a description of each case as well as the collective case. Chapter five consists of an in-depth discussion of the findings with relevant links to literature in the field. Finally, chapter six concludes the thesis, detailing the limitations and implications of the study.

CHAPTER ONE

1. INTRODUCTION

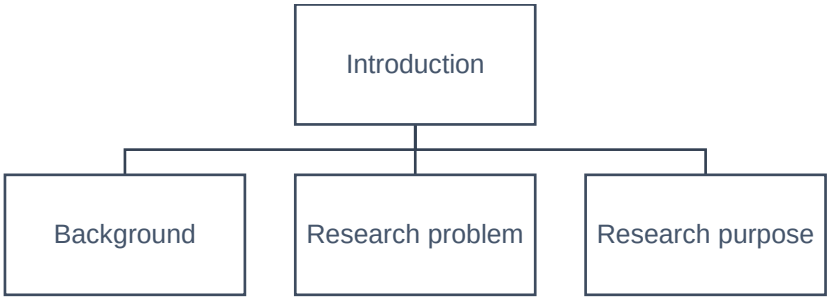


Figure 1- An overview of the content covered in this chapter.

1.1. Background

The burden of mental illness in the last decade has significantly increased globally (Jack, Wagner, Petersen, Thom, Newton, Stein, Kahn, Tollman & Hofman, 2014). According to Ritchie and Roser (2018), one in six people in South Africa would have a mental illness and/or would have had exposure to mental illness in their lifetime. According to Duncan, Swartz & Kathard (2011), the health care system in South Africa continues to be increasingly burdened by the growing prevalence of instances of mental illness and subsequently mental health care users (MHCUs). In a systematic review conducted between 2000 and 2010, Sorsdahl, Stein & Lund (2012) found that the burden of mental illness was substantial in the year 2000 and was likely to surge with the epidemiological change to chronic and non-communicable diseases, a tendency known to many low-and middle-income countries (LMICs) (such as South Africa). They therefore emphasised the significance of mental health services in South Africa.

“First, South African morbidity data indicates that mental disorders are the third highest contributor to the local burden of disease, after Human Immunodeficiency Virus (HIV) and other infectious diseases. Second, interpersonal violence is highly prevalent in South Africa, and is associated with major psychiatric morbidity. Third, both HIV and substance use have extremely important associations with mental disorders in our context. Fourth, there are major links between poverty and mental illness, mediated by a range of factors other than food insufficiency” (Sorsdahl et al., 2012, p.168). The combination of an array of risk factors for mental illness such as HIV, interpersonal violence, substance use, food insecurity and poverty makes the context of South Africa unique, impacting the upward trajectory of the prevalence of mental illness, its morbidity and risk factors (Yatham, Sivathasan, Yoon, da Silva & Ravindran, 2018). Amidst the increasing

trajectory of mental illness in South Africa females presented with a higher prevalence of mental illness and were found to be more vulnerable to mental illness than males (Jack et al., 2014; Jacob & Coetzee, 2018). A similar higher prevalence of mental illness amongst females holds true in other LMICs across the globe (Van Ditzhuijzen, Ten Have, De Graaf, Van Nijnatten & Vollebergh, 2017; Brown, Wilton, Ray, Dennis, Guttmann & Vigod, 2019; Yatham et al., 2018). The foreseeable increase of mental illness and subsequent mental health care users (MHCUs) makes for Ritchie & Roser (2018), the treatment of mental illness subject to scrutiny, investigation and ultimately improvement.

In addition, the treatment of mental illness in South African under the apartheid regime in the 1960's exemplified the historical injustices in South Africa (Martin, Arbour & Stevens, 2019). Mental illness was known as a debilitating illness, where people diagnosed with a chronic mental illness were treated in large psychiatric hospitals for prolonged periods of time, alienated from society. The outcomes of their treatment were poor (Martin et al., 2019). There were seldom opportunities for MHCUs to become integrated members of society (Martin et al., 2019).

In South Africa in recent years, however, since the 2000 current legislation was instated in the redress and treatment of mental illness has transitioned toward deinstitutionalisation and recovery-orientated care (Western Cape Government (WCG), 2014). Current South African legislation is geared towards redressing the social injustices of the past (WCG, 2014). Healthcare 2030 is the legislative framework, that was formed in the redress. It outlines the Department of Health's (DoH) vision for Health care services for the next ten years. The document outlines psychiatric services as a priority (WCG, 2014), details of which are explained in chapter two of this thesis. There is moreover global consensus in legislative frameworks around the value of decentralisation, as the future of mental health services (Ashby, Gray, Ryan, & James, 2015; Jack et al., 2014; Jacob & Coetzee, 2018; Perkes, Whiteford, Charlesworth, Weekes, Jones, Brindle, Hoare, Todd & Ray, 2015; WCG, 2014).

Alongside the change in South African legislation has been a movement toward recovery-orientated care. A package of care used globally in the treatment of mental illness (Ashby et al., 2015; De Vos & Leclair, 2019; Doroud, Fossey & Fortune, 2015; Mental Health Commission, 2005; Synovec, 2015; Townsend & Polatajko, 2013). Similar, to the redress in the legislation, the recovery-orientated care steers away from the traditional medical model and way of treating mental illness. The recovery-orientated care is a package of care developed for people with mental illness, it is a perspective that holds that recovery does not mean to be free of symptoms of mental illness but to live meaningful lives despite having persistent symptoms of mental illness (Doroud et al., 2015). The recovery-orientated care emphasises building resilience and support

amongst MHCUs. Hope, empowerment and, holism is guiding principles of recovery to attain wellness. The current study is situated within the recovery-orientated care package.

Alongside the reform of recovery-orientated care, outlined in Healthcare 2030, DeAngelis, Mollo, Giordano, Scotten & Fecondo (2019) claim that in mental health services at tertiary levels, discharge programmes should include collaboration between health professionals and MHCUs that ensures patient-centred care. The claim of DeAngelis et al (2019), moreover, is that recovery-orientated discharge programmes should afford MHCUs with opportunities of skills development and stress management, budgeting skills, relapse prevention skills, as well as vocational and academic opportunities that will assist with the transition from tertiary psychiatric facilities to community reintegration (DeAngelis et al., 2019). Occupational Therapy (OT), a profession that is rooted in psychiatry, identifies mental health practice as a key area to focus on for the twenty first century, identifying in particular the value of recovery-orientated-care (DeAngelis et al., 2019). As an Occupational Therapist, the researcher holds that an occupation-based approach is essential to the existence of the Occupational Therapy profession as argued by Townsend & Polatajko (2013) and that is fundamental to human health and well-being as put forward by Christiansen & Townsend (2004). Engagement in occupations provide humans with a sense of purpose and structure. Furthermore, occupations shape identities and reflect values and culture (Ikiugu, Nissen, Bellar, Maassen & Van Peursem, 2017).

Engagement in meaningful occupations amongst MHCUs may offer the opportunity for re-establishing identities (Doroud et al., 2015). Occupations provide opportunities for developing skills that are important for independent community living. Discharge programmes that include meaningful engagement install a sense of hope, lessen psychiatric symptoms, create an opportunity for socialisation and foster social inclusion (De Vos & Leclair, 2019). Meaningful occupational engagement in psychiatric discharge programmes empower MHCUs to ultimately improve their functioning in occupational performance, create opportunities and improve their quality of life (Doroud et al., 2015; Ikiugu et al., 2017; De Vos & Leclair, 2019). To be denied an opportunity to engage in meaningful occupational engagement is an injustice synonymous with the social injustices that existed historically in South Africa (Hocking, 2017). Since MHCUs in the community are often denied the opportunity of skills development, personal growth, and employment (Frank & Muriithi, 2015), and the opportunity of restabilising their occupational journeys could be associated with alienation and exclusion (Kronenberg, Kathard, Rudman & Ramugondo, 2015).

Occupational engagement of MHCUs would, in general install the possibility of hope and the experience of purpose and meaning within the routine and structure that is specific to their individual needs. Occupational engagement also provides persons with a sense of meaning, purpose, and identity (Ikiugu et al., 2017; Morris & Cox, 2017; Townsend & Polatajko, 2013). The lack of available opportunities for occupational engagement results in occupational injustice (Kronenberg et al., 2015). Similarly, the lack of occupational engagement has a direct effect on the readmission rates of MHCUs (Watters, Pearce, Backman & Suto, 2012).

1.2. Research problem

The research was conducted in the pre-discharge ward of the Female Admissions Unit (FAU) at a tertiary psychiatric facility in the Western Cape of South Africa (see figure 2 below). The study site was the pre-discharge ward (see more in section 3.6. Study Context). Various therapeutic group interventions relating mainly to life skills, were offered in the programme of the ward. However, apart from the therapeutic group interventions, the researcher observed that MHCUs were unoccupied. They had much unstructured time, and often complained of being bored. As an Occupational Therapist (OT), I understand the value of being engaged in an occupation; amongst others, it offers health benefits. I also regard the MHCUs as adults in the life stage of generativity, i.e. the stage of being contributing members of society as occupational beings (Watters et al., 2012). In this regard, the clinical observation of MHCUs as not being engaged in meaningful occupation pointed to a problem. Watters et al., (2012) suggest that the lack of meaningful occupational engagement amongst MHCUs could lead to deterioration of mental health, relapse, and readmission. Similarly, Doroud et al., (2015) argue that engaging in an array of occupations that are personally satisfying is vital for survival, health, and well-being. In contrast, fewer opportunities for occupational engagement could restrict personal growth and development of MHCUs (Morris & Cox, 2017).

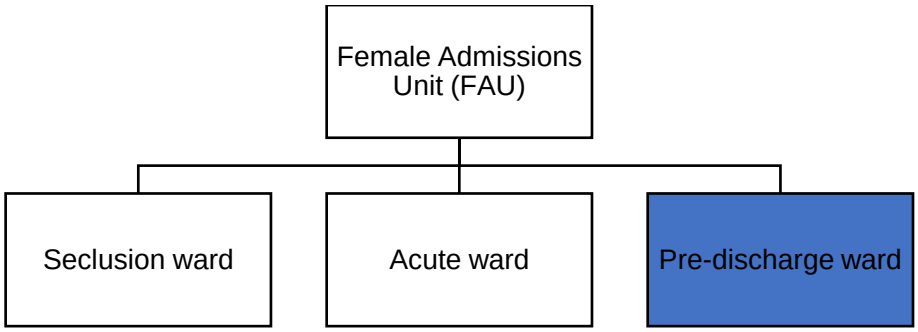


Figure 2- illustrates the composition of the FAU.

According to Hamer, Kidd, Clarke, Butler, & Lampshire (2017) the availability of fewer opportunities for occupational engagement excludes MHCUs from being contributing members of society. Furthermore, it reinforces social stigma and marginalizes MHCUs from broader society (Hamer et al., 2017). In addition, fewer occupational engagement opportunities lead to worsening psychiatric symptoms (Smyth, Harries & Dorer, 2011). Since OT is concerned with achieving balance lifestyle through the engagement in a variety of occupations, the current study set out to describe the occupational engagement of MHCUs in the pre-discharge ward in the FAU, to elucidate unexpressed needs of the MHCUs and to extrapolate recommendations for how the programme could better address patient recovery through occupational engagement.

1.3. Research purpose

In view of the benefits of meaningful occupational engagement for MHCUs, explained in the background of this study, this study, through describing MHCUs perspectives on occupational engagement, aims to assist in the understanding of the value of occupational engagement of pre-discharge MHCUs. These insights would aid in designing an occupation-based recovery-orientated OT programme. An occupation-based recovery OT programme would aim to create opportunities for meaningful occupational engagement in order to assist MHCUs in developing important skills towards community integration as independent individuals. Furthermore, such a programme is likely to aim toward social inclusion for MHCUs upon discharge, improving their quality of life. Meaningful occupational engagement in the pre-discharge ward would provide MHCUs with opportunities for establishing identities, creating purpose, and meaning in their lives, as well as working toward goals and a future as contributing members of their communities (Doroud et al., 2015).

Understanding the viewpoints of occupational engagement of female MHCUs creates an opportunity to render Occupational Therapy services that are patient-centred and that will speak to the needs of MHCUs. MHCUs reserve the occupational right of being afforded the opportunity of meaningful occupational engagement, that will aid them in realising and establishing their full potential attaining social and occupational justice (Hammel, 2015). Moreover, documented perspectives of MHCUs may provide input with regard to the extent of the inclusion of meaningful occupations as part of the pre-discharge ward occupation-focused recovery programme. The outcomes of this study would be able to be used alongside legislature, to align OT services that are responsive to MHCUs needs with the broader shift in health care services (WCG, 2014).

A prospective occupation-based recovery-orientated OT programme would foster inclusion and encourage independence amongst MHCUs. This inclusion and independence would in turn have the potential to directly lessen the burden of the disease that mental illness has on health services

in South Africa. The research of this thesis aims to advocate for female MHCUs, to bring their needs to the fore and to provide input into a programme that will be patient-centred. The findings will serve to improve Occupational Therapy services, inform OT practice and reiterate the importance of occupation-based practice and patient-centred care. It will also serve to inform stakeholders of the value of the OT role in the recovery of MHCUs. Finally, the purpose of the study was to understand the perspectives of MHCUs of their occupational engagement in the pre-discharge ward environment. Findings would inform the alignment of OT services according to the needs of MHCUs thus making services patient-centred which is in alignment with Healthcare 2030 and recovery-orientated-care.

Overview of chapter one

Chapter one elucidates the background of the study and explicates the research problem. The purpose of this research of exploring the perspectives of female MHCUs is elucidated as being to inform the development of a programme in the pre-discharge ward that offers meaningful occupational engagement for female MHCUs. Chapter two will review the literature that pertains to the research.

CHAPTER TWO

2. LITERATURE REVIEW

Introduction

In this chapter, an overview of the literature included, contextualising the burden of mental illness and the current mental health services globally and in South Africa, is given. The experiences of female MHCUs as inpatients at mental health facilities both globally and locally is explored. The perceptions of meaningful activities that enhance occupational engagement within pre-discharge psychiatric wards at tertiary levels are described. Lastly, occupational engagement and recovery-orientated practices in mental health are explained.

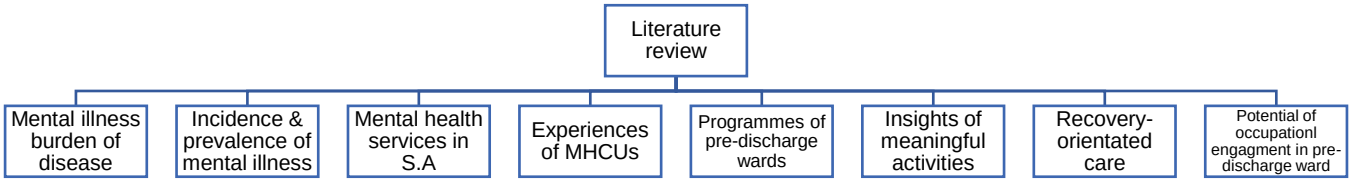


Figure - 3 The structure of the literature review.

2. 1. Mental illness and the burden of disease

2.1.1. Incidence and prevalence of mental illness amongst females globally

The WHO (2018) reported that the burden of mental illness continued to grow with substantial influence on health, social and, human rights and with economic consequences globally. The burden of mental illness in the last decade has significantly increased globally (Jack et al., 2014; Jacob & Coetzee, 2018). Van Ditzhuijzen et al., (2017) in a cohort amongst Dutch women in the Netherlands argued that women that endured adverse life events and had a lack of social support were more vulnerable to mental illness. The study included 325 women and was conducted between April 2010 and January 2011. The authors further argued that women in unstable intimate partner relationships that then become pregnant were more at risk of developing mental illness (Van Ditzhuijzen et al., 2017). They also found that women that have been exposed to several traumatic events were more at risk of future mental disorders (Van Ditzhuijzen et al., 2017).

Brown et al., (2019) conducted a population based retrospective cohort in Canada between 2005 and 2015. The authors argued that 1 in 5 women experience mental illness in pregnancy or post-partum. Stress and poor social support were amongst the sturdiest predictors of perinatal mental illness noted. Hence, women were more vulnerable to mental illness during their perinatal period. Brown et al., (2019) further argue that women with chronic diseases of lifestyle such as diabetes, hypertension and obesity to mention a few, are more at risk to developing mental illness. The incidence of mental illness in LMICs such as India, Afghanistan, Brazil, China, Turkey, Lebanon, Palestine, and South Africa accounts for the majority of the world's psychiatric disorders (Yatham et al., 2018). Many LMICs are affected by violence, lack of resources, natural disasters, substance misuse and environmental stressors (Yatham et al., 2018).

2.1.2. Incidence and prevalence of mental illness amongst females in South Africa

According to Jacob and Coetzee (2018), the burden of mental illness in South Africa cannot not be viewed in isolation of the risk factors. The risk factors of mental illness surpass the individual's attributes including ability to cope with emotions and manage one's thoughts, behaviours and interactions with others. Risk factors of mental health were noted as being systemic in nature, including environmental factors such as national policies, social protection, and socio-political factors such as socio-economic circumstances (Jacob & Coetzee, 2018), standard of living, employment status, and exposure to hazards within the environment (WHO, 2018). Jacob and Coetzee (2018) and WHO (2018) attributed risk factors for mental illness to psychosocial factors often larger than simply the individual's attributes and genetic pre-disposition. Risk factors as determinants of mental illness particularly place females in South Africa at a higher risk of mental illness (Jacob & Coetzee, 2018).

In South Africa, females have been found to be more vulnerable to mental illness during the perinatal period (Jacob & Coetzee, 2018; Mandelli, Petrelli & Serretti, 2015), a finding similar to that of Brown et al., (2019). Moreover, female MHCUs in the Western Cape of South Africa were often found to have been exposed to childhood trauma (Field, Onah, Van Heyningen & Honikman, 2018), sexual assault, gender-based violence as adults, illicit substance use and significant socio-economic life stressors, making them vulnerable to mental illness (Jacob & Coetzee, 2018). Mizock (2019) in a similar finding in a pilot study in America, argued that females experience mental illness differently, in the course of illness, symptoms and treatment response when compared to males and that trauma, life stressors, substance use and gender-based violence were significant contributing factors to mental illness amongst females. Females are complex in

nature, because they often have to deal with additional factors such as exposure to sexual abuse, trauma, intimate partner violence, poverty, single parenting and HIV (Mizock, 2019). The studies by Mizock (2019) and Field et al., (2018) demonstrate how a high-risk environment affected female MHCUs' mental health. Similarly, in Canada, Brown et al., (2019) argued that women that had poor social support were more likely to be diagnosed with mental illness. Intimate partner violence, lack of social support, food insecurity, a lack of resources, HIV and an array of social injustices are unique to South Africa and other LMICs (Sorsdahl et al., 2012). These factors are strong predictors of mental illness amongst females in South Africa (Sorsdahl et al., 2012).

According to Jack et al., (2014) 1 in 6 South Africans would suffer from mental illness in their lifetime; this is a higher prevalence than in Canada, or in other LMICs where the rate is 1 in 5 (Jack et al., 2014). According to Kessler, Anguilar-Gaxiola, Alonso, Chatterji, Lee, Ormel, Üstün & Wang (2009), the prevalence of those with mental disorders in South Africa was 30.3%, 12 % in Nigeria, 25.8% in Lebanon, 26.1% in Mexico and 39.1% in Columbia. Yu (2018) found that mental illness was more prevalent amongst females than males. According to Du Toit, Niehaus, Jordaan, Koen, Jones & Leppanen (2020), the prevalence of perinatal depression and suicide is high amongst females in South Africa. Mental illness accounts for 14% of the global burden of disease (Yatham et al., 2018) and 80% of the world's MHCUs are from LMICs (WHO, 2011). Poverty and psychosocial stressors such as violence and conflict expose people in LMICs to mental disorders (Du Toit et al., 2020; Yatham et al., 2018). Women in South Africa and other LMICs are at higher risk for perinatal mental disorders due to their exposure to socio-economic risk factors such as intimate partner violence, low levels of education, food insecurity, poverty, substance use, HIV and a lack of access to adequate health and social services (Burger, Hoosain, Einspieler, Unger & Niehaus, 2020).

Jacob & Coetzee, 2018; Jack et al., 2014; WHO, 2018 found that mental illness remained one of the contributing illnesses to the burden of disease in South African and globally According to the national disability adjusted life years (DALY) from the burden of disease study (Jack et al., 2014), in South Africa, neuropsychiatric disorders were graded third, after HIV and other infectious diseases, as contributors to the burden of disease, surpassing other non-communicable diseases in this regard (Jack et al., 2014; Jacob & Coetzee, 2018). “In the Western Cape, the prevalence of anxiety disorders was 18.9%, that of mood disorders 13.7% and that of substance use disorders 20.6%” (Jacob & Coetzee, 2018, p. 176). Approximately 21 million people are living with schizophrenia globally, of which the majority were found to be in LMICs and this coincided with the highest gaps in treatment, LMICs (Charlson, Ferrari, Santomauro, Diminic, Stockings, Scott, McGrath & Whiteford, 2018).

The prevalence of mental illness was analysed and a profile of MHCUs was done by Franken, Wicomb, Allen & Parker (2018) in a study conducted at the same facility as this study was done. Of the 573 adult psychiatric patients profiled, the following was reported: “The median age of the cohort was 29 years. Most patients (63%) were educated to secondary level. Only 12% of patients were employed and 37% received disability grants. More than 90% of cases presented with psychotic symptoms. Of these, 28% presented with first episode psychosis. Of all patients, 20% had been referred with manic symptoms and 7% with depressive symptoms. Many patients (62%) used substances in the period leading up to admission. Significantly, more males (73%) used substances compared to females. Cannabis was the most widely used substance (51%), followed by methamphetamine (36%). Violence was a contributing factor in 37% of admissions. A total of 70 patients (13%) tested positive for HIV, while 49 (9%) tested positive for syphilis” (Franken et al., 2018, p. 1).

The South African Stress and Health (SASH) data (Sorsdahl et al., 2012) suggested that the high prevalence of mental illness could be attributed to exposure to trauma, societal stressors during apartheid, ongoing racial tension and post-apartheid inequalities. The levels of intimate partner violence, sexual trauma and poverty experienced by women in South Africa makes them more vulnerable to mental illness (Mandelli et al., 2015). Females presented with a higher prevalence of mental illness than males and were more vulnerable to mental illness (Jack et al., 2014; Jacob & Coetzee, 2018). Sorsdahl et al., (2012) argue in the SASH, that South Africa has a unique post-apartheid socio-economic and cultural context of inequalities and income inequalities. Social injustices remain imminent in post-apartheid South Africa (Kronenberg et al., 2015; Frank & Muriithi, 2015). Societal stressors such as high rates of violence and poverty (WCG, 2014; WHO, 2013) aggravate mental illnesses. Historical social, political and economic injustices continue to exist in previously disadvantaged communities, pre-disposing females to ill health and mental illness.

2.1.3. Mental health services in South Africa

The Department of Health (DoH) envisions quality health services for MHCUs. Patient-centred care is a priority in the Healthcare 2030 plan for services (WCG, 2014). The prioritization of patient-centred care that is responsive to the needs of MHCUs is important and situates this study in the bigger sphere of policy plans in terms of health services in South Africa. Making Occupational Therapy services patient-centred will improve the MHCU experience of the services (WCG, 2014). Healthcare 2030 endorses a patient-centred approach to service delivery in South Africa (WCG, 2014). Delivering of quality health services, though patient-centred care, creates a substantial foundation toward the process of addressing the increasing burden of disease and

toward achieving wellness (WCG, 2014). The MHCUs experience of healthcare services was found to be an important indicator to the success of the intervention sought and prognosis of mental illness; hence, in South Africa's vision for health, a large sum of resources was allocated to improving the inpatient experience (WCG, 2014).

Psychosocial approaches in interventions used in psychiatry are plausible, especially with the move from traditional medical models. The medical model of disability views the professional as the expert in the treatment of mental illness. The professional will make recommendations and adjustments to the treatment regime according to their assessment of the mental illness, with little or no input from service user (Rudnick, 2018). The medical model places the professional in a position of dominance and the patient in the position of being in receipt of care by the professional (Rudnick, 2018). The professional is expected to fix the impairment of the service user. The medical model views the illness as the problem. Differing from this, the social model of disability views disability in the context of society (Rudnick, 2018). It attempts to understand the person amidst contextual influences - political, social, temporal and geographical - and their impact on the individual. The key differences between the social and medical models of disability are those of power relations and holism. In the social model of disability MHCUs are viewed as experts in their own lives, which means that persons with mental illness are considered to know their own health needs and the reality of their lives better than professionals (Rudnick, 2018).

Psychosocial rehabilitation (PSR) is an approach used in psychiatry, situated within the social model of disability. The PSR is based on the premise of an integrated approach in care for MHCUs. PSR involves a holistic approach that focuses on patient-centred care, differentiating it from the medical model of disability (Rudnick, 2018). In addition, PSR uses an interdisciplinary approach; this includes the use of a multidisciplinary team (MDT) as well as intersectoral collaboration (Rudnick, 2018). Occupational Therapy views people as occupational beings with their own, unique sets of values, roles and occupations. The profession also shares principles with PSR and recovery-orientated care - all of which adopt an integrated, collaborative and holistic approach to intervention, where the MHCU is empowered and takes ownership of their health and well-being (Rudnick, 2018). The exploration and improved understanding of the occupational engagement of MHCUs in the pre-discharge ward offered by the present study would contribute to the interventions and services that are responsive to the needs of MHCUs in the provision of patient-centred care.

A case study by Breen, Swartz, Flisher, Joska, Corrigall, Plaatjies & McDonald (2007) found that the poor quality of tertiary psychiatric services in the Western Cape resulted in the psychosocial requirements of MHCUs being largely unmet, with the highest requirement for psychosocial services being found amongst the least educated. Psychosocial needs are defined as

independent living skills and life skills (communication, problem solving, goal setting, self-awareness etc), the need for support systems within and around the community, the need for employment and the need for inclusive programmes for MHCUs (Breen et al., 2007). The improvement of mental health care services at tertiary psychiatric facilities has been planned in conjunction with the strengthening of community services, as set out in Healthcare 2030 (WCG, 2014). These efforts have emphasised the patient experience and have been aimed at empowering MHCUs. They seek “to address the detail in, amongst others, what we mean by integrated mental health service, giving voice to the mental health patient, preventing stigma, identifying what capacity and training is required at different levels and specifically the interrelationship between levels of care and institutions to ensure continuity of care for the patient” (WCG, 2014, p. 61).

2.2. Experiences of female MHCUs in pre-discharge wards

2.2.1. Global context

Lindgren, Molin, Lundström, Strömbäck, Renberg & Ringnér (2018) in their single-system experimental design, compared a psychiatric inpatient unit pre- and post-implementation of the novel spatial design, in Sweden. They argued that physical environments in psychiatric inpatient units were not prioritised in comparison to other speciality hospitals. Inconsistencies in operations in psychiatric speciality hospitals made MHCUs feel confused, unpleasant and bored in the ward (Lindgren et al., 2018). Organisational structure and management of psychiatric inpatient units was found to affect the ward structure and environment. Similarly, Pelto-Piri, Wallsten, Hylén, Nikban & Kjellin (2019) in a Swedish qualitative study, argue that factors such as poor communication and stigmatising remarks from staff made MHCUs feel as if they were less than human and contributed to a negative therapeutic relationship. Additionally, inconsistent ward rules, rigid routines and the lack of the seeking of input from MHCUs were found to be distressing for MHCUs and made them feel unsafe in the ward (Pelto-Piri et al., 2019). In contrast, it was found that respectful communication from staff to patients reduced MHCUs' stress and anxiety, installed hope and had a positive impact on the therapeutic relationship.

Kennedy and Fortune (2014), in a qualitative study at Melbourne Hospital, Australia, captured the experiences of female MHCUs of being in a tertiary psychiatric unit through an occupational lens. The inpatient psychiatric ward was situated within a tertiary psychiatric facility. Kennedy and Fortune (2014) found that MHCUs had dehumanising experiences, which were attributed to a shortage of staff, poor infrastructure, lack of privacy and poor patient to staff communication. According to Kennedy and Fortune (2014) living in hospital was difficult for the MHCUs because

they felt restricted, unsafe and out of their comfort zones. The lack of autonomy was found to be a common experience; females did not have access to required items such as toiletries (Kennedy & Fortune, 2014). Furthermore, MHCUs expressed feeling demeaned, less of a person by the way that they were spoken to and they felt unheard by staff (Kennedy & Fortune, 2014). MHCUs had to wait long periods to speak to staff to make requests, which made them feel as if they were passive recipients of care (Bryant, Cordingley, Sims, Dokal-Marandi, Pritchard, Stannard & Adamako, 2016; Kennedy & Fortune, 2014).

Likewise, Wright, Rowley, Chopra, Gregoriou & Waring (2016) in Nottingham, found that MHCUs had a negative experience of their admission to psychiatric inpatient facilities, explaining that their experiences were chaotic, stressful and, emotionally charged. Similarly, Summers and Happell (2003) in Australia, found that poor communication and inadequate coordination of care between inpatient and community psychiatric services negatively affected MHCUs experience of these inpatient tertiary psychiatric services. Bryant et al., (2016) in a qualitative study in UK, in understanding the perspectives of MHCUs in a pre-discharge inpatient environment, found that MHCUs perceived the ward environment as restrictive in many ways and felt as if they were constantly being monitored. Furthermore, MHCUs understood that the combination of the restrictive environment, and constant monitoring, was contrary to their mental health and well-being. Tertiary inpatient psychiatric facilities were also perceived as socially poor and boring by patients.

Bryant et al., (2016) argued that the restrictive nature of psychiatric wards impacted all involved, referring to both MHCUs and the staff in the ward. Staff negative attitudes and the fact of undermining the recovery of MHCUs affected the quality of service provision, which in turn, once again had an impact on MHCUs recovery. Pelto-Piri et al., (2019) stated that the fact of not having stimulating activities in the ward and the MHCUs poor social abilities made them feel distressed and anxious. Often the restrictive ward environments in psychiatric facilities were compared to prisons (Gilburt, Rose & Slade, 2008). In the UK, they found tertiary psychiatric facilities to have an absence of freedom and they were compared to prisons, with MHCUs fulfilling the role of the prisoners receiving punishment (Gilburt et al., 2008). In Australia Kennedy and Fortune's study (2014) had focused on females in particular. They found that females had a negative experience in the tertiary psychiatric facilities and that this was due to poor communication from staff, the restricted environment, the lack of autonomy and the fact of being bored. All of this furthermore made them feel unsafe. Similarly, Summers and Happell (2003) in Australia found that poor communication negatively affected MHCUs' experiences of inpatient psychiatric facilities.

In Sweden, Lindgren et al., (2018) found that physical environments are not prioritized in tertiary psychiatric facilities. They also found that inconsistent practices in tertiary psychiatric facilities made MHCUs feel confused, contributed to unpleasant environments and that MHCUs were bored. That the MHCUs were bored in the ward was also found by Kennedy & Fortune (2014) in Australia. Pelto-Piri et al., (2019) also in Sweden, argue that poor communication, stigmatizing remarks from staff, rigid rules and lack of input from MHCUs made them feel as though they were less than human. Poor communication, rigid rules and inconsistencies were similarly found to be part of the MHCUs reality in the studies of Kennedy & Fortune (2014), Lindgren et al., (2018) and in Summers and Happell (2003). Nottingham, Wright et al., (2016) similarly argued that inpatient tertiary psychiatric facilities were chaotic and stressful for the MHCUs, who also experienced poor communication.

In the UK, Bryant et al., (2016) found that inpatient tertiary psychiatric facilities were restrictive. They found that MHCUs were being monitored, that the environment was socially poor and boring and that these factors in turn made MHCUs feel anxious and distressed. Similar findings were found in the Swedish studies above. A limitation, however, of these studies presented above is that only Kennedy and Fortune (2014) focused on the experience of females whereas all the other studies focused on the experiences of MHCUs, not delineating males from females. From the literature above, it can be deduced that MHCUs on a global scale have had negative experiences of inpatient tertiary psychiatric facilities.

Townsend (2012), in a qualitative study in Canada, argued that the Canadian legislation acknowledges that mental health is a human right and has since been addressing mental health through various programmes. However, pointed out that historical boundaries excluding MHCUs from participating in their everyday occupations exhibited a lack of equal opportunities. Townsend (2012) moreover expressed that gender-based violence against female MHCUs further alienates them. An example of the historic exclusion and alienation of female MHCUs from developing their true potential was their institutionalisation. Hamer et al., (2017) posit that MHCUs are often excluded from the taken-for granted daily occupations that people without a mental illness usually enjoy, contributing to their marginalisation and the occupational injustices against them.

Hultqvist, Eklund and Leufstadius (2014) argued that meaningful occupational engagement of MHCUs positively affected their functionality and adaptability at discharge, which relates to how well MHCUs reintegrate into their respective communities. How well MHCUs integrate into their communities determines how functional they are; and their functionality impacts on their occupational engagement. Additionally, they found that the lack of occupational engagement in tertiary psychiatric institutes ultimately increased readmission rates. Pollard & Sakellariou (2012), supported by Hamer et al., (2017) and Hultqvist et al., (2014) argue that when MHCUs are not

engaged in occupations and not provided with an opportunity to engage in occupations that they become occupationally-deprived, victims of occupational apartheid and marginalised from society for having a mental illness.

2.2.2. South African context

Mayers, Keet, Winkler and Flisher (2010), in a qualitative study conducted in South Africa tertiary psychiatric facilities, found that inadequate communication between MHCUs and service providers was perceived by MHCUs as being that their human rights were infringed upon. Mkize (2007) in a study carried out at KwaZulu Natal Hospital revealed that MHCUs reporting dehumanising experiences and human rights abuses in several tertiary psychiatric facilities within South Africa. The lack of privacy and dehumanising experiences amongst MHCUs at tertiary psychiatric facilities were found to be evident in South Africa. (Mayers et al., 2010; Mkize, 2007). Recordings of the experiences of MHCUs in tertiary psychiatric facilities in South Africa were found to be lacking in the literature (Jack et al., 2014). Fewer studies were conducted in South Africa that demonstrated the need for research on the needs of MHCUs within a South African context (Jack et al., 2014; Jacob & Coetzee, 2018).

The experience of MHCUs at tertiary psychiatric services ill-equipped them for living as integrated community members post discharge (Smith, De Witt, Franzsen, Pillay, Wolfe & Davies, 2014). This study by Smith et al., (2014) was carried out as a descriptive cross-sectional study in South Africa of 26 MHCUs who were diagnosed with schizophrenia of which 19 were males and 7 were females. All participants were recruited from low socio-economic backgrounds. In this study, Smith et al., (2014) further identified that MHCUs had difficulty with the interpersonal skills required for connecting with people and for developing supportive networks. The lack of support, post-discharge, would place MHCUs at risk of conflict, which in turn could act as a stressor triggering relapse and subsequent readmission.

Moosa and Jeenah (2008) have argued that there are several factors that affect the experiences of MHCUs of tertiary psychiatric services in South Africa. They argue that the implementation of the Mental Health Care Act (MHCA) 17 of 2002 of South Africa infringes on the rights of MHCUs. However, “establishing and sustaining a supportive clinical relationship amid care giver and MHCUs can be challenging for mental health service providers in South Africa. They may have to overrule MHCUs protests and advocate involuntary treatment in services that are often not favourable to good care and not in the least restrictive environment. It was therefore debatable as to whether the involuntary treatment was preserving MHCUs sense of autonomy and whether it was good patient advocacy” (Moosa & Jeenah, 2008, p. 111). The above quote highlights the controversial nature of implementing the MHCA yet respecting the human dignity and autonomy

of MHCUs in tertiary psychiatric facilities in South Africa. Moosa and Jeenah (2008) argue that the implementation of the MHCA is controversial, as it infringes on MHCUs rights and autonomy but also has the responsibility of maintaining the dignity of MHCUs. Similarly, Petersen and Lund (2011) highlighted the need for the implementation of the MHCA within a human rights framework in South Africa. According to Petersen and Lund (2011) the MHCA should be implemented in such a manner that it does not infringe on the human rights of MHCUs.

2.3. Programmes of pre-discharge wards and the transition to community living

The first month after discharge from a tertiary psychiatric facility is critical in the life of MHCUs. The risk of readmission is high in the first month because MHCUs would have been used to the highly-structured hospital environment, where programmes also have high levels of supervision (Kidd, Virdee, Mihalakakos, McKinney, Feingold, Collins, Davidson, Weingarten, Maples & Velligan, 2016). At discharge, with the transition to community living, MHCUs do not have the same structured environment, making them vulnerable to relapse (Kidd et al., 2016).

Kidd et al., (2016) conducted a mixed method design study to examine a 6-week peer support programme at a large tertiary psychiatric facility in Canada. The peer support programme, called the Welcome-Basket was initiated pre-discharge. It had three phases. The Welcome Basket programme was aimed at facilitating transition from tertiary facility towards community reintegration. The study recruited 23 participants, 30.4% of the sample were females, unemployed and mainly dependent on disability benefits as an income source (Kidd et al., 2016). The programme demonstrated through its three phases how a patient-centred approach is used. The first phase consisted of peer support intervention, where peer support workers held initial meetings with MHCUs 2 weeks prior to their discharge. Phase two focused in the transition from hospital to community living. It involved forming a plan with the MHCU for a home visit of their neighbourhood to familiarize themselves with local resources for support (Kidd et al., 2016). In Phase three, the focus was on post-discharge environmental support (Kidd et al., 2016).

Continued peer support and MHCU engagement pre and post discharge were central across the phases, ensuring a patient-centred approach that was responsive to the needs of MHCUs. Outcomes of the Welcome Basket intervention were that MHCUs experienced improved quality of life, better community reintegration and showed less psychiatric symptoms. MHCUs felt supported, hopeful and less anxious. The Welcome Basket intervention offered a patient-centred approach with a very different to standard inpatient care (Kidd et al., 2016).

Mathias, Mathias, Goicolea and Kermode (2018) in a case study in India argue that mental health inpatient programmes should address social exclusion and stigma and that they should focus on educating the general population so as to create awareness of mental illness. Additionally, pre-discharge programmes should engage with the social causes of mental ill health such as gender inequality and socio-economic disadvantages. The study focused on creating safe social spaces and creating, and strengthening existing partnerships (Mathias et al., 2018). Similarly, in South Africa part of the shift in health services has been to improve the MHCU experience in the provision of quality health services that are responsive to the needs of MHCUs, as stipulated in Healthcare 2030 (WCG, 2014).

2.4. Insights regarding meaningful activities that enhance occupational engagement

It is important to consider the environment in the pre-discharge ward, since factors in the environment have the potential to either restrict or enhance occupational engagement; hence, the environment affects occupational engagement of MHCUs (Law, Cooper & Strong, 1996). Occupational Therapist's usually take into consideration the person holistically within the environment and believe that there is an symbiotic relationship between the person, which in this study is the female MHCU, the environment, which is the pre-discharge ward and occupation, which is the occupational engagement of the female MHCU.

Kennedy and Fortune (2014) argued that female MHCUs desired engagement in activities that were of greater meaning to them. Often activities presented in pre-discharge wards were not meaningful to MHCUs. Meaningful activities had the potential to enhance their occupational engagement (Bryant et al., 2016; Kennedy & Fortune, 2014). Over and above was MHCUs' desire to do more in the ward, they felt that there was little to do and that they would sit idle. MHCUs perceived the ward to be non-stimulating and requested a wider variety of activities to choose from which would not limit their engagement in repetitive activities (Bryant et al., 2016; Kennedy & Fortune, 2014). MHCUs perceived the absence of activities in the ward as concerning for their mental health. They understood the importance of doing something meaningful and recognised the benefits of occupation (Bryant et al., 2016).

Juxtaposed with the needs of MHCUs, Bryant et al., (2016) argued that ensuring the safety of MHCUs and staff was a priority in the ward followed by the need to meet basic needs including the provision of physical and health care activities. He outlines that the provision of manual occupation-based interventions such as cooking, home management tasks of cleaning, making tea, or a sandwich in the wards at tertiary psychiatric facilities could be identified as a need, yet poses risks to MHCUs because the equipment, such as a knife used to make a sandwich, could

also be used to hurt themselves or others. Nevertheless, Bryant et al., (2016) has been the only study to attribute the lack of stimulation in the ward environment to the inability to provide meaningful activities - because they might be a risk for MHCUs. It would, however, be useful to note that ideally, MHCUs should pose less of a risk to themselves and to others when they are assessed as mentally stable enough to be transferred to a pre-discharge ward. Kennedy and Fortune (2014), Lindgren et al., (2018) and Pelto-Piri et al., (2019) have also argued the need for more meaningful activities in inpatient wards at tertiary psychiatric facilities.

In contrast to the environments described above and describing another alternative, Ulfseth, Josephsson and Alsaker (2015) conducted a narrative enquiry about the construction of meaning in everyday occupation at a tertiary psychiatric centre in Norway with 7 inpatients, of which 6 were females and 1 was male. The ward had a 9-bed capacity. The environment was relaxed; both staff and MHCUs were engaged in occupations together. The living room in the ward was where MHCUs usually gathered. According to Ulfseth et al., (2015), the physical space of the living room had curtains, a bookshelf, coffee, a dining table with a tablecloth, soft sofas and armchairs with pillows. It was decorated with pot plants and had a relaxed atmosphere that was informal with a furnished home-like feel to it. MHCUs could share the living space to relax with a cup of coffee and to socialise or read.

The ward also had a terrace that opened into the garden that was available to MHCUs. Ulfseth et al., (2015) described the inpatient tertiary psychiatric facility as an aesthetically-pleasing physical environment that provided opportunities for meaningful occupational engagement. Whereas Bryant et al., (2016), Kennedy and Fortune (2014), Lindgren et al., (2018) all described the environment of tertiary psychiatric facilities as socially-poor and boring, Ulfseth et al., (2015) argued that in this facility MHCUs were engaged in meaningful occupations, through a structured programme that was organised according to weeks and days. The programme included everyday tasks and occupations, both obligatory and voluntary. The study demonstrates a structured inpatient psychiatric environment that is non-threatening. Here MHCUs had autonomy; the environment was less restrictive and created opportunities for meaningful occupational engagement. It must be noted though that Ulfseth et al., (2015) did not detail the mental health status of MHCUs nor did they detail the readmission rates, which are significant indicators of the success rates of a programme. In addition, what must be kept in consideration is that the ward was at a centre with a low bed capacity and had more amenities and available resources compared to the pre-discharge ward in the current study.

2.5. Recovery-orientated care

Recovery-orientated care is a subjective and personal journey for MHCUs (Martin et al., 2019). Recovery-oriented care refers to an approach where MHCUs are included in their recovery process, through establishing partnerships between the professional and MHCUs, so that the interventions are tailored at their needs (Martin et al., 2019). The recovery-orientated care steers away from a curative stance in the treatment of mental illness. Instead it is based on the premise that recovery from mental illness is possible, and that it is an ongoing journey instead of being curative (DeAngelis et al., 2019). Recovery-orientated care views recovery as an enduring process that focuses on empowerment of MHCUs towards self-management, developing personal growth, resilience and the installation of hope (DeAngelis et al., 2019).

Recovery-orientated care promotes an integrated and all-inclusive approach in the treatment of mental illness. Understanding the occupational engagement of female MHCUs in the pre-discharge ward environment is the first step toward creating a programme that is recovery-orientated, that focuses on the needs of MHCUs in a way that includes locating opportunities for re-establishing identities through occupational engagement and fosters patient-centred care in the broader sphere of health care services. “Recovery-orientated care in mental health services accentuated the healing process as recovery from mental illness and promoted a patient-centred approach to intervention. It further emphasized the importance of services that facilitated personal growth towards recovery. By doing so, it does not disregard the neurobiological aspects of the major mental illnesses but promotes a balance, as it identifies that the individual’s personhood and experience of their world to be inextricable” (Mental Health Commission, 2005, p.4). Recovery-orientated-care supports subjectivity and personal values. Similarly, occupation-based practice refers to the use of occupation-based approaches of assessment, such as task analysis and interventions through using occupation to achieve an end and/or as an end, in practice (Ashby et al., 2015). Townsend and Polatajko (2013) support the use of occupation-based practice and explain that occupations have therapeutic potential that contributed to the health and well-being of humans (Townsend & Polatajko, 2013).

Synovec (2015) demonstrates positive outcomes amongst MHCUs in a qualitative study with MHCUs in a pre-discharge ward at tertiary psychiatric facility where they participated in an occupation-based OT programme that integrated the ten principles of recovery-orientated care in interventions. The OT individual- and group-meetings included a variation of patient-centred, recovery-based and goal-orientated, occupation-based activities (Synovec, 2015). Sessions occurred daily for the duration of 60 minutes and incorporated a variety of modalities such as role playing, worksheets, discussions and in-context practice. The attendance of the sessions was

however dependent on acuity of illness, length of stay and availability of MHCUs. The topic of sessions was based on the goals set by MHCUs upon entering the programme (Synovec, 2015). The OT programme focused on “assisting MHCUs to identify their personal and contextual strength and ways to problem solve perceived barriers can increase self-esteem, self-efficacy and spiritual well-being, along with skill-based treatment to increase perceived control, confidence in performance, and occupational engagement in the community” (Synovec, 2015, p. 52).

Recovery-orientated programmes and occupation-based programmes are similar because they share principles that are embedded in their practices (Doroud et al., 2015). Both occupation-based and recovery-orientated programmes view the person holistically. For a holistic view of the person, all factors that impact on the MHCU are taken into consideration such as mental illness, environment, access to services, type of and availability of support within the community and individual strengths and weaknesses (Doroud et al., 2015: Synovec, 2015). Social functioning, relationships and family structure, insight into illness, adherence to medication, education and employment status are key areas of focus in both occupation-based and recovery-orientated practices (Doroud et al., 2015). Both occupation-based and recovery-orientated practices believe that the person, which in this study is the female MHCU, knows their life circumstances and needs, including their needs in intervention, making these health services, especially OT services, patient-centred (Doroud et al., 2015; Synovec, 2015). Marrying occupation-based and recovery-orientated care in OT practice in mental health has evidently produced good outcomes for MHCUs (Synovec, 2015). Empowerment was an important finding of these treatment approaches as it was characterised by hope to take the necessary steps in the process to recovery. Using principles from recovery-orientated care in OT skills training for health management resonates well with the holistic component within both the recovery and occupation-based practices (Synovec, 2015).

Doroud et al., (2015) in a scoping review conducted in Australia, focused on recovery as an occupational journey and made explicit connections between occupational engagement and recovery-orientated care of MHCUs. Doroud et al., (2015) argued that occupations provided MHCUs with the opportunity for the development of an identity, to establish meaning and purpose. Recovery through occupational engagement developed competency toward being contributing members of society (Doroud et al., 2015). Recovery using occupation was viewed as an occupational journey, which occurred over time in the rediscovery of the person who was recovering from mental illness. Together, recovery through occupations offered an opportunity for new experiences, in ordinary contexts, that fostered elements of hope, connectedness, meaning and empowerment (Doroud et al., 2015). The occupational journey towards recovery is made up of “(i) recovery as a gradual occupational re-engagement- doing to get started; (ii) recovery as

engaging within the stream of everyday occupational life and (iii) recovery as full community participation and citizenship" (Doroud et al., 2015, p. 380). In-hospital rehabilitation in a discharge ward in a tertiary hospital comprises the first phase of recovery through re-engagement in occupation. The re-introduction of occupations is gradual and partial with no pre-planned outcomes and social expectations. This phase is getting the person started in doing something, instead of doing nothing. Sutton, Hocking and Smythe (2012) warn this should be gradual, simple in instruction and execution and tasks and should not be too demanding. The scoping review of Doroud et al., (2015) however, was broader than exclusively the occupational engagement of inpatient tertiary psychiatric facilities, it included a review of occupational engagement in ordinary day-to-day contexts, applicability thereof to the service context might thus vary.

Similarly, De Vos and Leclair (2019) utilised recovery and occupation in their study and demonstrated the value and meaning of a food skills group amongst MHCUs in an urban tertiary psychiatric facility. The OT would upon selection of group members enquire about their preferences in terms of dishes, which were culturally appropriate to the group. The group was skills based and required MHCUs in the pre-discharge ward to learn to cook from a systematic recipe. Planning and organisation, safety in the kitchen and preparing culturally-appropriate food were some of the skills fostered. De Vos and Leclair (2019) demonstrated a systematic process of occupational engagement, using principles of recovery-orientated care, of doing to get started. Initial tasks were not demanding and occurred over time, building-up to the accomplishment of cooking a meal. The food skills group provided MHCUs with the prospect of developing new skills, which contributed to the recovery of members. It highlighted the importance of *doing* in the pre-discharge ward of a tertiary psychiatric facility and its contribution to their recovery.

The group process also provided a platform for social participation and a sense of belonging. It moreover demonstrated how occupation can be used to achieve an end and how occupation can be used as an end (De Vos & Leclair, 2019). The study is one of a few studies in the literature that is concerned with the occupational engagement of MHCUs in a tertiary psychiatric facility. The study of De Vos and Leclair (2019), however, does not delineate the referral criteria of the MHCUs that attended the food skills group, making it difficult to duplicate. Importantly the study was conducted in Britain, a high-income country, in contrast to a resource-constrained South Africa as a LMIC (WCG, 2014), where the ratio of MHCU to therapist is high, making exact duplication of the process in this context difficult. In the literature, meaning and purpose of occupational engagement amongst MHCUs (Doroud et al., 2015; Synovec, 2015) and the clinical effects of OT are well-documented (Ikiugu et al., 2017). However, literature on occupational engagement amongst MHCUs in pre-discharge wards in tertiary psychiatric facilities is significantly lacking (De Vos & Leclair, 2019).

2.5.1. The potential of occupational engagement in pre-discharge wards

Research in the field suggests that affording equal opportunities to MHCUs in pre-discharge wards at tertiary psychiatric facilities (Frank & Muriithi, 2015) to engage in meaningful occupations and find purpose therein contributes to a positive self-worth (Lin, Kirsh, Polatajko, & Seto, 2009; Smith et al., 2014). Ikiugu et al., (2017) similarly argue, in their meta-analysis on the clinical effectiveness of OT in mental health services, that, when engaged in meaningful occupations, MHCUs showed improvement in occupational performance in their self-maintenance, productivity and social participation. Likewise, Synovec's (2015) qualitative study at inpatient tertiary psychiatric facilities that included recovery-orientated principles in the OT programme found that occupational engagement improved self-management and independent community living, both of which are psychosocial factors. However, Synovec's (2015) study did not detail the environmental factors in terms of restrained resources, which the present study operates within. Additionally, Doroud et al., (2015), in a scoping review based in Australia, argues that meaningful occupational engagement provides MHCUs with the opportunity to re-establish their occupational identities. The opportunity of meaningful occupational engagement amongst MHCUs provides them with the opportunity to rediscover themselves through the occupational journey (Doroud et al., 2015).

De Vos and Leclair (2019), in a convergent-mixed methods study in a tertiary psychiatric facility in Canada, demonstrate the value of occupation in meal preparation in a food skills group. The group used in the study was heterogeneous, a combination of males and females who had a variety of schizophrenia- and bipolar-associated disorders. The sample size was 80 MHCUs. De Vos and Leclair (2019) contend that the occupation of meal preparation provided the opportunity for socialization, offering MHCUs a sense of belonging and support. In addition, MHCUs had to share their meal at lunch in conversation, which role modelled positive social participation and created a supportive network amongst MHCUs.

The food skills group of De Vos and Leclair's (2019) study required MHCUs to share in the responsibilities of meal preparation, which required the further skills of time management in the kitchen, cleaning up, setting the table, being safe with working on the stove and following a recipe, The food skills group required planning and organisation of events in a logical and systematic manner; it also required effective communication between MHCUs and a level of responsiveness. The above-listed performance skills are affected by symptoms of mental illness. Moreover, the meal preparation also offered the opportunity of enhancing prior cooking skills and of acquiring new skills such as nutritional cooking and budgeting. In sum, the kitchen offered a space to enhance valuable skills required for independent community living (De Vos & Leclair, 2019).

Likewise, Ulfseth et al., (2015) in a narrative enquiry conducted in the 9-bed centres in Norway, argue that meaning making is just as important for MHCUs as it is for people without mental illness. In the centre, MHCUs were given a structured programme to follow that was designed according to the needs of MHCUs and staff. The programme for the MHCUs was separated into work obligations and leisure periods, occupations and chores that included both obligatory and voluntary tasks. It included morning walks and fitness training, or other exercises. It also included time for relaxing with coffee or a book or a newspaper, music, knitting, social conversations, various games, or simply just sitting together in the living room as a leisure activity. The study highlighted that engaging in everyday occupations in the ward created opportunities for social participation (Ulfseth et al., 2015).

Ulfseth et al., (2015) in their enquiry, furthermore, gave attention specifically to social participation in meaning making amongst MHCUs. All participants were older than 40 years and most were females. A MHCU in the study started a conversation with fellow MHCUs about a pair of jeans that he used to wear in the 80's. This then triggered a spontaneous response from another MHCU in the living room and she shared a memory of a pair of jeans that she once owned. This in turn was then followed by the spontaneous participation of another MHCU. The initial conversation about the pair of jeans had triggered memories amongst fellow MHCUs, who spontaneously contributed to the conversation. Eventually, the conversation led to stories of the 80's. The communicative process herein demonstrates mimesis. The social participation demonstrated the value of human contact, as connectedness that forges bonds, making it meaningful to the MHCUs in the study (Ulfseth et al., 2015). Engagement in the everyday occupation of social participation is important; it is often something that is affected by symptoms of mental illness. However, in a group, the human contact created a space for interpersonal skills, social connectedness and that when shared; the experience thereof nurtured hope and a supportive space in pre-discharge wards in tertiary psychiatric facilities (Ulfseth et al., 2015).

Likewise, Zimolag and Krupa (2009) in a mixed methods study in Canada studied pet ownership as a meaningful community occupation amongst MHCUs. 60 MHCUs that were part of the assertive community treatment team (ACT), which is an established multidisciplinary team that goes out into the community to support MHCUs who often post discharge struggle with support and adhering to medication. The ACT team completed the survey. 38 of the MHCUs were female and mostly pet owners, 24 were male and none-pet owners. The group of pet owners demonstrated positive community integration in comparison with the group of none-pet owners in the study. Zimolag and Krupa (2009) argued that, just like motherhood, caring for animals is an occupation that is socially constructed in femininity. Pet owners in the study showed a higher mean in global assessment of functioning than none-pet owners. Zimolag and Krupa (2009) held that the pet ownership was meaningful because it provided social participation and contributed to

the sense of belonging of MHCUs, which broadened their network of support within the community. Pet-owners demonstrated skills required of caring for a pet, such as feeding, nurturing, going for regular walks, which assisted with the development of routine and structure in the lives of female MHCU pet owners (Zimolag & Krupa, 2009). Caring for the pet, had an affirmative influence on their self-esteem and shaped the identity of female MHCUs (Zimolag & Krupa, 2009).

In the literature, social participation is found to be a common need amongst female MHCUs (Ulfseth et al., 2015; Zimolag & Krupa, 2009). Occupations were found to foster social inclusion, a safe network of support and the opportunity to develop skills that empowered MHCUs toward independent community living at discharge (De Vos & Leclair, 2019). Furthermore, occupational engagement in pre-discharge wards provided the opportunity to redefine the occupational identities, which was synonymous with the description of Watters et al., (2012) of how engagement in the occupation of Ikebana reflected the relationship between meaningful occupational engagement and well-being. The study of Watters et al., (2012) further reiterates how meaningful occupational engagement as paramount for well-being.

2.6. Research question

What are the perspectives of female MHCUs of their occupational engagement in the pre-discharge ward within a tertiary psychiatric facility?

2.7. Research aim

The aim of the study was to explore the perspectives of female MHCUs of their occupational engagement in a pre-discharge ward within a tertiary psychiatric facility.

2.8. Research objectives

- To describe the views of female MHCUs of what occupational engagement entails in the pre-discharge ward environment.
- To explore female MHCUs' perspectives of the pre-discharge ward environment.
- To extrapolate suggestions and to make recommendations to the pre-discharge ward programme.

Overview of chapter two

The literature highlight the burden of mental illness both globally and locally. It emphasizes the shift in mental health services from the dominant medical model and toward recovery-orientated care that fosters patient-centred care. The literature also reveals the need for patient-centred interventions as part of health services for MHCUs to be prioritized. There are still, however, gaps in the literature with regards to mental health services understanding the needs of MHCUs, to align the services appropriately. In particular, inquiry into the needs of female MHCUs in South Africa. The literature highlights negative inpatient experiences of MHCUs and expressions of the lack of opportunities for occupational engagement are common, both globally and locally. Recovery-orientated occupational engagement programmes are mainly found in Canada. Examples and descriptions of the benefits of occupational engagement amongst MHCUs in pre-discharge wards are plentiful. Fewer studies of the occupational engagement of MHCUs are found in the South African context. This study is situated to fill an important gap in the literature of a greater understanding of the value of occupational engagement and also to provide evidence for the needs of female MHCUs in this regard - all to be able to be used to deliver patient-centred Occupational Therapy services. The following chapter will delineate the methodology used in the study.

CHAPTER THREE

3. METHODOLOGY

Chapter Overview

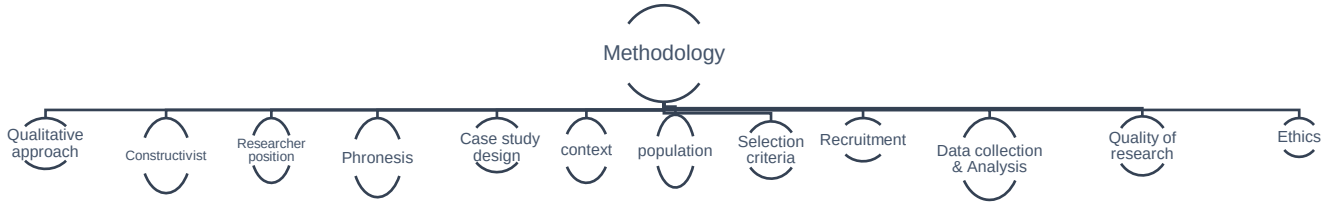


Figure 4 - The chapter overview of chapter 3.

Introduction

The aim of this study is to explore the perspectives of female MHCUs occupational engagement in the pre-discharge ward at a tertiary psychiatric facility. Understanding the occupational engagement of MHCUs will inform initiatives that are important for improving OT services and enhancing patient-centredness in the treatment approach of the MHCUs at the facility where the research was conducted. The study uses the constructivist paradigm as a lens to investigate the viewpoints of participants' occupational engagement in the pre-discharge ward environment. The qualitative approach and case study design respectively guided the research. The case was described as the occupational engagement of female MHCUs in the pre-discharge ward. The study population was female MHCUs that were in the in the pre-discharge ward at the time that the research was conducted. Purposive sampling strategies were employed. Participants had to meet a selection criterion to be recruited into the study. Ethical considerations were adhered to and applied to all methods throughout this study.

3.1. Qualitative approach

A qualitative approach was used for the exploration of the topic by engaging directly with the participants being studied (Bell, 2010; Donalek, 2004) through the collection of textual data. Qualitative research permits for capturing the human experience (Ayers, Kavanaugh, & Knafl, 2003; Bell, 2010). Qualitative researchers usually collect multiple accounts of an experience within a common context so as to capture the topic under study (Ayers et al., 2003). The qualitative approach permits for the investigation of multiple worldview points of the female MHCUs, making it best suited to answer the research question at hand. Kumar (2019) iterated the value of qualitative case studies as enabling the investigation using numerous data sources, which ensured the topic under study was well understood. In this study multiple data sources such as interviews, document analysis, participant observations and survey data were used to investigate the occupational engagement of female MHCUs in the pre-discharge ward.

3.2. Constructivist paradigm

Constructivists depend on the participants' view of the condition under study (Creswell, 2014). Constructivists seek to understand the intricacy of views and aim to understand how humans construct meaning about the phenomena under investigation (Creswell, 2014). Constructivists believe that persons create individual meanings of their experiences and that meanings vary with manifold interpretations (Creswell, 2014). The constructivist paradigm enabled the researcher to present the individual meanings of the MHCUs whilst recognizing that their perspectives were manifold. Furthermore, it took into account that the constructions were rooted in their individual meanings, which were shaped by their individual circumstances. Within the constructivist paradigm the researcher considered MHCUs personal, cultural and historical experiences and how these temporal aspects contributed to their perspectives and descriptions of their interpretation of their occupational engagement in the pre-discharge ward. The constructivist paradigm allowed the researcher to identify the significance of the subjective construction of meaning by MHCUs, yet not disregard an objective point of view (Baxter & Jack, 2008).

Constructivists operate from the premise that the truth is relative (Yin, 2009). Constructivism is based on the principle of the social construction of reality (Baxter & Jack, 2008). One of the advantages of using this approach was that it allowed for the forming of close partnerships between the researcher and the MHCUs. Developing rapport with MHCUs enabled the MHCUs to share their stories and describe the views of their realities and enabled the researcher to gain insight into understanding their perspectives (Kumar, 2019). The researcher developed rapport with MHCUs throughout the research process so as to enable them to openly share their viewpoints.

3.3. Researcher position in the research

Occupational therapists, as clinicians and researchers may find themselves in conflict with the two roles respectively (Kielhofner, 2006). Since I have been the resident practitioner in the pre-discharge ward for the past six years, I was particularly mindful of distinguishing between the role of clinician and researcher in this study. Since establishing rapport with MHCUs was imperative for the research, it was equally essential for me, as a researcher, to establish boundaries with MHCUs as participants so as to ensure that ethical obligations were fulfilled. In implementing boundaries, the first step that I had to take to mitigate this risk of conflicting roles, was to declare and delineate the researcher role apart from my role as a clinician role.

As a researcher I employed the following measures that clarified my position as a researcher: Interviews were held outside of clinical times. I ensured that when I had contact with the MHCUs that I declared my interest as a researcher and delineated my role from that of a clinician. Through this action I demonstrated openness and transparency, two important qualities to ensure the credibility of the research. Additionally, these qualities also ensured the upkeep of MHCUs rights to make informed decisions about their choice to participate in the study. Thus, maintaining a balance between the clinician and researcher role. Clinical work usually occurred in the pre-discharge ward. As a researcher, I arranged that research interviews occurred in a separate building from the clinical setting. In addition, some of my patients enrolled to be participants in the study. I referred these patients to another clinician Occupational Therapist, working in the Female Admissions Unit (FAU). I also dressed in ordinary civilian clothing for research interviews, whilst as a clinician I wear a uniform. As a researcher I was present in the pre-discharge ward on weekends, which I am not usually as a clinician.

Furthermore, putting to action openness and transparency, as a researcher I provided the MHCUs in the study with all the necessary information pertaining to the study i.e. interviews, ward programme, participants observations and the Activities Clock (Cynkin & Robinson, 1990). Thus, ensured that MHCUs were well informed about what was expected of them as participants in the research. MHCUs were assured of the purpose of the study and that their viewpoints would not be used in their clinical management, once again demonstrating openness, transparency and providing clarity between the researcher and clinician role. Records of clinical notes are generally made on group feedback forms which are then filed in the patient folders. As a researcher, I recorded field notes in a separate handheld journal.

In addition, upon obtaining their consent to be part of the study and throughout interaction with participants in accordance with research-related activities, I as the researcher assured MHCUs that any information provided by them (their viewpoints), as part of the study, would be treated

with the utmost confidentiality. The information provided from participants was not shared with the multidisciplinary team (MDT) and did not impact on their treatment regimes in the pre-discharge ward. This action demonstrated openness, transparency and the delineation of the role of the researcher from the clinician in this study.

3.4. Phronesis

Bardone and Lind (2016) define phronesis as the state of capacity (Bardone & Lind, 2016). This capacity assists people in handling their practical affairs (Bardone & Lind, 2016; Kronenberg et al., 2015). It is often translated as practical wisdom. Bardone and Lind (2016) elaborate that phronesis refers essentially to those conditions that require people to be thoughtful and act in a manner that is virtuous. In the research phronesis is an attempt to capture the type of knowledge that can be positioned in practical situations, and, as such, it addresses the relationship between theory and practice (Gadamer, 2004). Phronesis is a derivative of accountable research and is an approach to research with vulnerable groups of people, and the complexity of social human affairs (Bardone & Lind, 2016). In this study phronesis was important because the researcher was aware that she was a position of power and authority. Being mindful of this position of power, she showed compassion towards MHCUs, without imposing her views onto them. During the research the researcher created an environment that was safe for MHCUs to share their experiences and created a relationship that was respectful. The female MHCUs in this study are part of a marginalised group, not only because of their mental illnesses but because their environments make them more vulnerable to abuse and exploitation (WHO, 2011). The protection of their rights is therefore of utmost importance. In this research the researcher ensured that the rights of female MHCUs in this study were protected.

The researcher practiced phronesis by upholding an ethical and moral duty towards the MHCUs in the study. She did this by demonstrating openness and transparency throughout the planning and conducting of research. Open and honest communication, that clearly communicated the research purpose, process and expectations from MHCUs was ensured. Explanations were given in layman's terms to ensure that MHCUs fully understood what was expected of them as participants in this research. The above-indicated measures were practiced by the researcher, which ensured the upkeep of the rights of female MHCUs and simultaneously ensured that MHCUs were not exploited. In addition, the researcher demonstrated phronesis by not judging and showing respect for the viewpoints of the MHCUs and not exploiting them. The researcher in her interaction with participants and took care to capturing the findings of participants in a manner that it does not implicate or show participants in a negative light.

Phronesis, has been applied throughout the study through establishing rapport with MHCUs and in taking care to understand the deeper underpinnings of the lives of humans and occupation. Kronenberg, et al., (2015) in their work on healing and humanising post-apartheid South Africa, posit that occupation has the potential to re-humanise people and look to its potential to redress social injustices in South Africa. Interactions were ensured to convey respect for the choice of occupations by ensuring that the researcher conducted herself in a manner that was courteous, respectful and did not display judgment. Respect within interactions and discussions was encouraged, coupled with rapport and the hope of emerging to new practical wisdoms in the reconstruction of occupations amongst participants.

3.5. Case study design

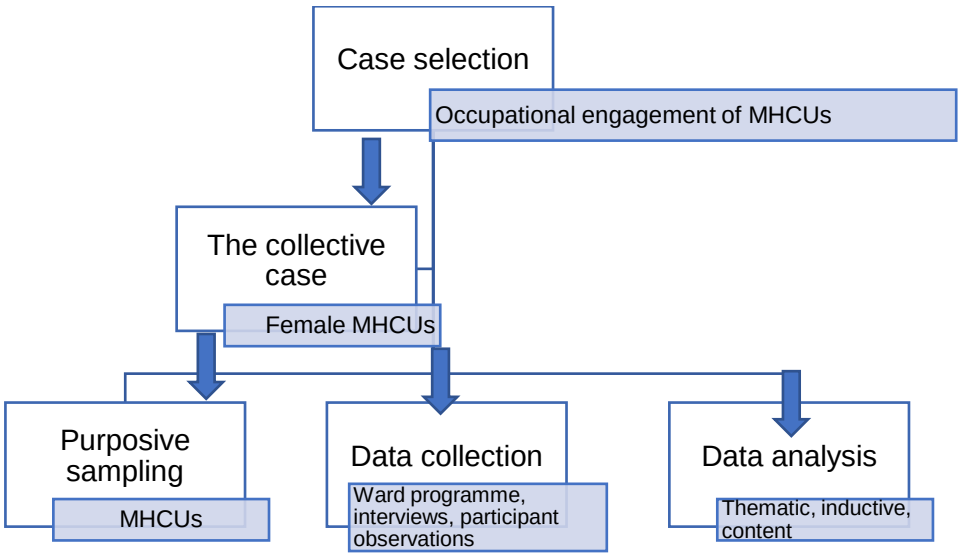


Figure 5 - The case study design.

3.5.1. Case study research

The case in this research was the occupational engagement of female MHCUs in the pre-discharge ward. Yin's (2009) approach of case study methods was used in this research. Yin (2009) finds the case study methods to be the best fit for people and programmes. Case studies remain renowned in organisational and health research (Yin, 2009). In this study, the emphasis was on developing a deeper understanding of the perspectives of female MHCUs occupational engagement in the pre-discharge ward at a tertiary psychiatric facility. The findings were used to extrapolate suggestions to the programme in the pre-discharge ward.

Case study research however was critiqued for its small sample size when compared to that of quantitative research, since the small sample size impacted on the generalisability of the findings (Yin, 2009). However, in this case study the sample size was small but endured intense analysis and multiple data sources were used (Zach, 2006). Additionally, the findings of this case study were not for the purpose of generalizability but to describe the occupational engagement of MHCUs in pre-discharge ward at a specific tertiary psychiatric setting which will be used to extrapolate recommendations for the programme in the pre-discharge ward. This will ultimately improve service delivery at the facility where the research was conducted.

Case studies cannot be studied out of the context. Case study research is rooted in the social sciences, especially sociology (Zach, 2006). Two key approaches are used in case study research, one proposed by Stake (1995) and the second by Yin (2009). Both Stake (1995) and Yin (2009) based their approach on a constructivist paradigm. Constructivists hold that the truth is relative and reliant on one's perspective (Baxter & Jack, 2008). Yin (2009) posits that case studies are empirical and emphasize the context of the case.

Case study research in Occupational Therapy, in a study by Hercegovac, Kernot & Stanley, (2019) focussing on how qualitative case study design informs Occupational Therapy practice, indicates how qualitative case study design in Occupational Therapy is important in understanding the underpinnings for complex phenomena. Furthermore, the use of qualitative case studies is an important method for investigating cases in their real-life contexts, complimenting the holistic viewpoints that Occupational Therapists use in practice (Hercegovac et al., 2019). This study, which intends on understanding the complex case of the occupational engagement of female MHCUs in view of the context of the pre-discharge ward in the FAU environment, involves such a context-dependent, subjective and holistic topic.

Case study research provides the opportunity to capture multiple worldviews and interpretations that optimize understanding of the topic (Ong, Cashwell & Downs, 2019). In this study the occupational engagement of female MHCUs was determined by the programme in the pre-discharge ward. The circumstances under which the MHCUs participated in the pre-discharge ward were explored to better understand and describe the occupational engagement of female MHCUs.

3.5.2. The Case

The case in this research was the occupational engagement of female MHCUs in the pre-discharge ward. The context of a case is multi-layered. It includes physical, cultural and social aspects (American Occupational Therapy Association, 2014). Of the case under study, the physical context refers to the non-human aspects of the context such as accessibility to resources and amenities in the pre-discharge ward. The cultural context refers to the accepted norms of the group of female MHCUs in the pre-discharge ward. The cultural context refers to political aspects and opportunities in employment and education. Binding the case, as in fencing off the boundaries as to what becomes the case, is an important responsibility of the researcher in case study research (Yin, 2009). In this study defining the context was an important boundary that was employed. Creswell (2014) suggests binding of a case through time and place. The time aspect related to the phase of recovery within hospital admission and specifically within the pre-discharge phase of in-hospital treatment. The aspect of place related to the place where participants found themselves during the pre-discharge phase of their rehabilitation process, namely the pre-discharge ward at a specific tertiary psychiatric facility in the Western Cape.

The case was bounded by defining the pre-discharge ward inside the tertiary psychiatric facility context, which was ward 17, the pre-discharge ward at a tertiary psychiatric facility in the Western Cape of South Africa, as the ward under study. The Female Admissions Unit (FAU) has three wards, a sub-acute, a seclusion and a pre-discharge ward. The pre-discharge ward has a 30-bed capacity. Here MHCUs are much improved in their mental state examinations (MSE). MHCUs in this ward are also more independent in their functioning. In total, the FAU is equipped to house 70 MHCUs. Additionally, with regard to the binding of the study, considering what the case was *not* going to be was an important binding mechanism of the case, further helping to focus the study.

Case studies are richly descriptive because they are grounded in various sources of information (Yin, 2009). Researchers who embark on case study research refer to single, multiple instrumental or collective case study design (Baxter & Jack, 2008). Each participant reflected a case, multiple participants, made up the collective case study. The collective case study design used to explore the perspectives of female MHCUs occupational engagement allowed the researcher to establish multiple viewpoints from the female MHCUs in the pre-discharge ward. Describing multiple viewpoints contributed to building a robust understanding of the case.

3.6. Study context

The hospital, in which the ward as the context of the study exists, is divided into numerous units. These units are often comprised of male and female admission wards and include a forensic unit, a male step-down unit, a child unit, a family and adolescent unit and an intellectual disability unit. This study was situated in the Female Admission Unit (FAU). The FAU comprises three wards. A 10-bed seclusion ward where MHCUs who, due to psychosis pose as either a homicidal or suicidal risk, are admitted. The Occupational Therapist does not render services in the seclusion ward. Next is the 30-bed sub-acute ward. Here MHCUs are transferred from the 10-bed seclusion ward once improvement has been noted in their MSE and functioning. Alternatively, MHCUs can also be admitted directly to the larger 30-bed sub-acute ward, pending the outcome of their initial assessment on admission. MHCUs in the sub-acute ward pose less of a risk to themselves and to others and are usually starting to engage with the therapists. In the sub-acute ward medication adjustments, social investigations and return to work negotiations are investigated and pursued. In addition, discharge plans are initiated and addressed by members of the multidisciplinary team (MDT). The Occupational Therapists render services in the sub-acute and pre-discharge wards. Once the MDT assess MHCUs as indicating noticeable improvements in overall functioning and in their MSE, they are then transferred to the pre-discharge ward. The pre-discharge ward has a 30-bed capacity. Here MHCUs are much improved in their MSEs. They are also more independent in their functioning. In total the FAU is equipped to house 70 MHCUs. The average length of inpatient stay in either of the admissions wards in December 2016 was 45.3 days (Lentegeur Hospital Statistics Report, 2016).

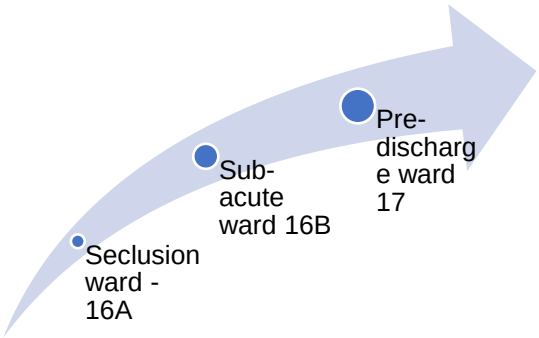


Figure 6 - Movement of MHCUs across the wards of the FAU.

The present study was conducted within the pre-discharge ward of the FAU. The MDT consisted of the same MDT members across all the wards in the FAU. The MDT was made up of a Consultant Psychiatrist who heads the team, two Medical Officers (MO), who are also case managers, Nursing staff, one Psychologist, one Physiotherapist (PT) and two Social Workers (SW). At the time the research commenced the FAU only had one Occupational Therapist. An

additional half-day Occupational Therapist was later employed in the FAU. In the pre-discharge ward, planning by the MDT for the MHCUs is focused on community reintegration, learnerships, return to previous roles and preparation for life outside of the tertiary psychiatric facility. This planning process includes building the relevant supportive networks and makes necessary referrals to various stake holders. All MHCUs in the pre-discharge ward are required to adhere to the programme in the ward (Appendix 1).

The programme of the pre-discharge ward consisted, at the time of the study, of tasks and activities related to activities of daily living (ADLs), i.e. eating, sleeping, bathing, leisure activities, taking of medication and therapeutic group interventions. The therapeutic group interventions followed a themed seven-week roster, with one theme per week, of which groups had to occur within a theme-specific week. Week one's theme was "What is Mental Illness," week two's was "Stigma", week three was "The Role of Treatment" and so forth, among the list of topics (see Table 1 below). Each discipline was required to provide specific group interventions according to the themes. These sessions were mainly didactic. Occupation-based groups, which were mainly crafts, occurred once a week, with approximately 10 MHCUs in the occupation-based groups. MHCUs were referred to the occupation-based group as part of an assessment.

Pre-discharge seven-week therapeutic group intervention themes						
1. What is Mental Illness	2. Dealing with Stigma	3. The Role of Treatment	4. Substances	5. Self-Care	6. Maternal Mental Health	7. Recovery & Discharge Planning

Table 1 - The topics of therapeutic group interventions as part of the programme in the pre-discharge ward.

3.7. Study population

The population that was studied were MHCUs within the pre-discharge ward of the FAU. At the time of the study there were 30 MHCUs in the pre-discharge ward. MHCUs in the pre-discharge ward range in age from 18 to 59 years old. Approximately 30% these MHCUs have a diagnosis of bipolar-associated disorders and approximately 70% of schizophrenia-related disorders. The Diagnostic Statistical Manual Version five (DSM-V) of mental disorders explains that schizophrenia is diagnosed in the presence of one or both of hallucinations and/or delusions (psychosis), coupled with noticeable impairment in one or more areas of occupational functioning (American Psychiatric Association, 2013). According to the DSM-V, bipolar-related disorders include bipolar type I and II. Bipolar type I is described as a manic episode, persistently elevated mood, increased energy and activity for most of the day of every day. Bipolar type II is explained

as having at least one episode of major Depression and a hypomanic episode (American Psychiatric Association, 2013). Both schizophrenia and bipolar disorders cause impairment in functioning (American Psychiatric Association, 2013). Approximately 40% of the total population in the pre-discharge ward had attempted suicide prior to their admission to the hospital. Approximately 70% of the total population of the pre-discharge ward had been identified as being a risk to themselves and others prior to the admission and were certified under the MHCA 17 of 2002.

80% of MHCUs in the pre-discharge ward had exposure to trauma and abuse (intimate partner violence, sexual abuse, financial abuse or physical abuse) at some stage in their lives. 70% of the population in the pre-discharge ward had exposure to substance misuse at some point in their lives prior to their admission. Methamphetamine, cannabis, dagga and alcohol were the most used substances. 90% of the pre-discharge ward had previous admissions to tertiary psychiatric services. 90% of the MHCUs in the pre-discharge ward came from constrained socio-economic circumstances. Approximately 90% of MHCUs in the pre-discharge ward did not have a grade 12-level of education. Approximately 10% had a grade 12-level and higher levels of education. 90% of MHCUs in the pre-discharge ward was unemployed at the time the study was conducted. The female MHCUs in the pre-discharge ward were mainly from disadvantaged areas (Group Areas Act 41 of 1950) with challenging socio-economic circumstances. The cultural environments of MHCUs in the pre-discharge ward had been impacted by the Group Areas Act no. 41 of 1950 of the apartheid Government of South Africa when it forcefully separated people and assigned various employment and education pursuits according to racial orientation. People of colour, namely “blacks," "coloureds" and "Indians” were limited to unskilled or semi-skilled labour (Group Areas Act 41 of 1950), which to a large extent dictated the physical home environments of MHCUs in the pre-discharge ward. Resource-constrained physical environments, low education and unemployment rates and were the realities of the MHCUs prior to their admission to the pre-discharge ward. Approximately 60% of MHCUs in the pre-discharge ward had little- and some no-access to basic amenities such as running water, food and electricity. Approximately 70% of MHCUs in the pre-discharge ward relied on disability and child grants as an income. 90% of the pre-discharge ward was able to communicate in English. English, Afrikaans and IsiXhosa were the three most common languages spoken by MHCUs in the pre-discharge ward. Co-morbidities such as HIV, TB and chronic diseases of lifestyle such as Diabetes were also present amongst MHCUs in the pre-discharge ward.

3.8. Sampling

Purposive sampling in case study research (Yin, 2009) was used to select participants for this study; participants were chosen according to who could best answer the research question (Creswell, 2014; Kumar, 2019). Female MHCUs who had had direct experience in the pre-discharge ward environment, at the time of the research were considered best able to provide insights into their occupational engagement in the ward and thus most suited to answer the research question (Hays & Wood, 2011; Yin, 2009). Female MHCUs in the pre-discharge ward who met the selection criterion were recruited to the study. Over the duration of 6 months, 12 out of 30 of the MHCUs in the pre-discharge ward approached the researcher and verbally communicated interest and willingness to participate in the study (Creswell, 2014; Yin, 2009). These 12 formed the initial group of participants. 2 out of the 12 MHCUs were discharged due to bed pressure and 1 out of the 12 was devolved into the community, making it difficult for this MHCU to follow-up for assessment of mental state examination (MSE) once discharged. 4 out of the 12 participants were assessed as having negative capacity to consent and did not meet the selection criteria and were excluded. A total of 5 (*n* = 5 out of 12) MHCUs were successfully recruited, which represented 17% of the total population MHCUs in the pre-discharge ward.

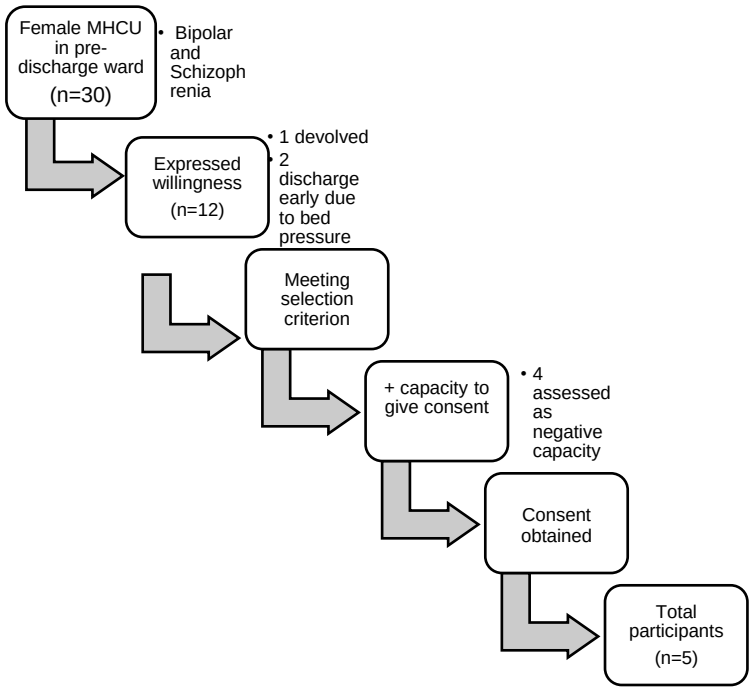


Figure 7- Recruitment of participants against the selection criteria.

Eventually a total of five (n=5) participants made up the sample. The median age of the participants was 23 years old. Diagnoses included bipolar disorder and schizophrenia. 3 out of 5 participants had been exposed to illicit substances in their lifetime and also had the co-morbidity of HIV. 5 out of 5 of the MHCUs had been exposed to trauma and abuse in their lifetime. 3 out of

5 participants had received a tertiary education. 4 out of 5 participants were currently unemployed. 3 out of 5 participants had a previous admission to psychiatric services. One participant only completed one interview. Several attempts were made to contact her after discharge but were unsuccessful. (Appendix 2 – description of participants).

3.9. Selection Criteria

Participants had to meet the following selection criterion to be recruited to the study. All items of the selection criterion had to be met.

- MHCUs with bipolar- and schizophrenia-related disorders were included in the study, as it was the two most common mental illnesses that female MHCUs in the pre-discharge ward were diagnosed with.
- MHCUs had to display interest and willingness to partake in the study.
- MHCUs who participated had to be without psychosis.
- MHCUs had to have been assessed as having a positive capacity to consent to participate in the research.

3.10. Recruitment

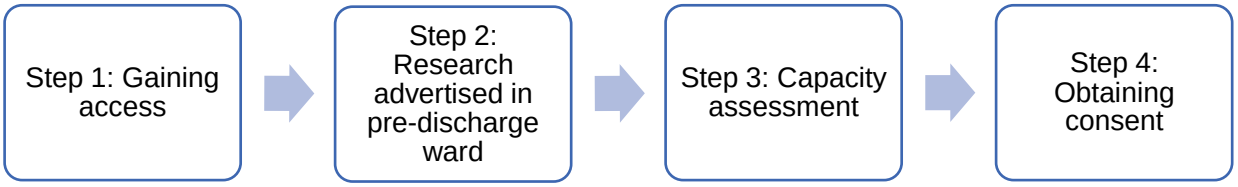


Figure 8 - The steps taken in the recruitment process.

3.10.1. Step 1: Gaining access

The study received ethical approval from the Health Research Ethics Committee at Stellenbosch University (Appendix 3). Thereafter the researcher followed the necessary steps in gaining permission from the Department of Health (DoH) in the gaining access to participants, which were female MHCUs at a tertiary psychiatric Government health facility in the Western Cape. Approval was granted from the DoH and access was granted to the female MHCUs in the pre-discharge ward (Appendix 4).

3.10.2. Step 2: Research advertised in the pre-discharge ward

Not all MHCUs were recruited simultaneously. MHCUs were recruited at different intervals during the research process, over the duration of six months (Yin, 2009). The operational manager of the ward announced the project to all MHCUs in the ward, the researcher also placed a notice on the board in the pre-discharge ward with details of the project and requested that interested individuals approach the researcher. Interested MHCUs approached the researcher for more information on the study. The researcher held a session with interested MHCUs in the pre-discharge ward where she explained the research in layman's terms. Potential participants were also discussed in the consultant psychiatrist ward round. Thereafter MHCUs were reminded weekly about the study, since new MHCUs were transferred weekly from the sub-acute ward to the pre-discharge ward. At every instance where MHCUs demonstrated interest in the study, the researcher explained the study to them in layman's terms. MHCUs displayed interest in the study; it was optional and a voluntary process, ensuring the autonomy of the MHCUs. The potential participants who had shown interest in the research were then screened against the selection criterion, which ascertained their eligibility to participate in the study.

3.10.3. Step 3: Capacity assessment

Only once MHCUs were assessed as mentally stable and without psychosis were, they assessed for having capacity to consent to the study. This was usually at the stage when they were closer to their discharge. They were assessed for having capacity to consent to the research by their treating Medical Officer (MO) in consultation with the head Consultant Psychiatrist. The treating MO provided the researcher with the outcome of the capacity assessment. All MHCUs that were successfully recruited received a bottle of hand lotion after completion of data collection, to thank them for participating in the study.

3.10.4. Step 4: Obtaining consent

Once MHCUs were assessed as having capacity to participate in the study, obtaining consent to participate was the next step, an important and final step of recruitment. MHCUs were approached by the researcher who gave them the consent and information sheets, which were made available in three of the eleven official languages. Details of the ethics and principles that applied can be found at 3.15.

3.11. Data collection

Type of data source	Purpose
1. Document analysis – programme in the pre-discharge ward	The programme in the pre-discharge ward was used to describe the occupational engagement of MHCUs.
2. Survey data - The- Activities Clock	A tool used to gather information on the occupations of MHCUs and to describe MHCUs views of their occupational engagements from which to extrapolate recommendations for the programme of the pre-discharge ward.
3. Interviews with MHCUs	To explore MHCUs voices on the environment in the pre-discharge ward.
4. Participant observations: daily activities during different times of the day.	Observations of participants whilst engaging with them in various activities. This was used to explore the environment of the pre-discharge ward.

Table 2 - The multiple data sources that were utilized in this study.

Four data sources were used to collect data for the present study (Kumar, 2019; Yin, 2009). Multiple-data sources, namely the programme in the pre-discharge ward, the Activities Clock, interviews and participant observations were used to build a robust case. The researcher engaged in 26 hours of data collection accounted by the various data sources. This time was delineated in each data source respectively. Data collection and analysis occurred concurrently (Creswell, 2014). Data was collected until saturation occurred (Yin, 2009).

Data collection occurred in the following order:

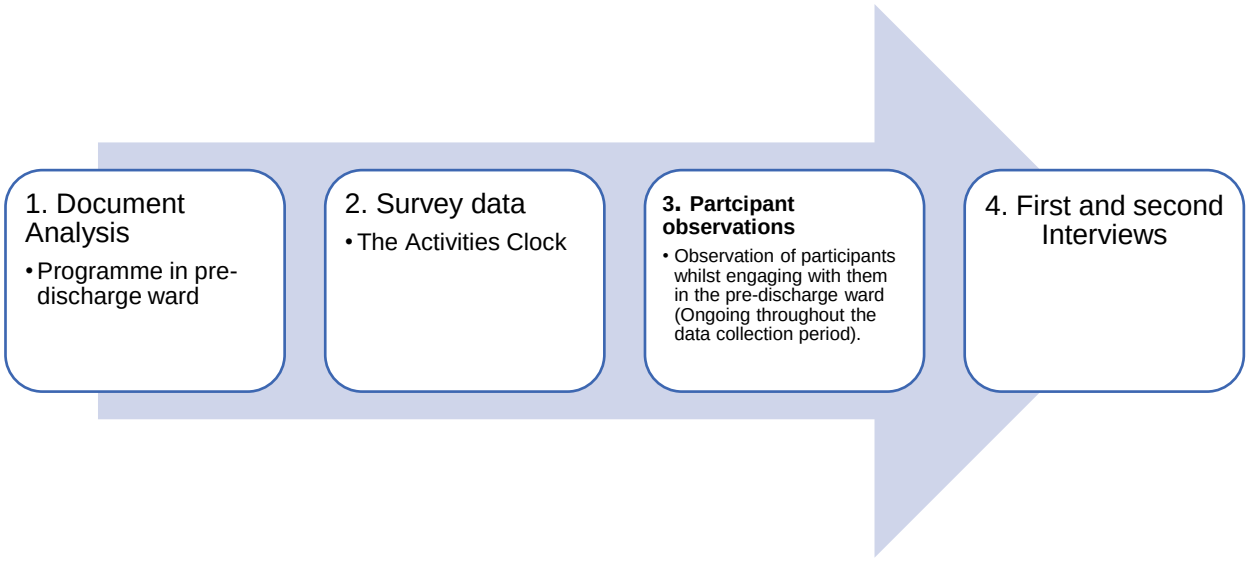


Figure 9 - The sequence in which data was collected.

3.11.1. Document Analysis: The programme in the pre-discharge ward

Documents analysis is a systematic procedure for reviewing or evaluating documents. The first data source used was the programme of the pre-discharge ward since it provided important information about the case enquiry (Hancock & Algozzine, 2009), as well as the time allocated to each activity during a 24-hour cycle. The programme of the pre-discharge ward assisted the researcher to gain a deeper understanding of activities and tasks enlisted as part of the programme in the pre-discharge ward. Documents were usually used in combination with other data sources as a means of triangulation. The programme in the pre-discharge ward was used in combinations with other qualitative data sources (interviews and participants observations). Information obtained from the programme in the pre-discharge ward was later used in the interview questions and observed in participant observations.

The programme in the pre-discharge ward was pasted up on the wall in the ward and was accessible to the MDT and public (people visiting). It detailed the routine (execution of various activities at specific times of the day), including specific daily activities such a basic activities of daily living (BADLs), leisure, rest and sleep as well as therapeutic activities .The routine of the ward programme was largely determined by the nursing component of the MDT and then alignment and co-ordination with the different disciplines was done to determine the group therapeutic activities. All female MHCUs had to follow the programme in the pre-discharge ward. Hence the ward programme as a document was an important data source for information on the time use and type of activities engaged in by the female MHCUs in the ward (Bowen, 2009).

3.11.2. The Activities Clock

What is unique to qualitative approaches within case study research is that researchers may gather quantitative survey data that facilitates a well-rounded understanding of the case under investigation (Baxter & Jack, 2008). The Activities Clock (Cynkin & Robinson, 1990), a self-report tool, was the second data source. This data was collected prior to the interviews, which was discussed in the interviews as well. Offering survey data, the Activities Clock is a useful tool for representing relative time allocated to broad categories of activities over time. The Activities Clock was used to gather information about the relevance and meaning of activities in the lives of the MHCUs. The Activities Clock would thus assist with the objective of extrapolating recommendations for the ward programme of relevant activities that would have meaning for MHCUs (Cynkin & Robinson, 1990). This information would be important that contributed to building the case for the occupational engagement of female MHCUs in the pre-discharge ward. The Activities Clock was simple to complete. All MHCUs completed it on their own in English (as the language they preferred). The time required for the execution and completion of the Activities

Clock amounted to one hour per participant, and collectively five hours for all the participants. The Activities Clock differed for each participant, since their occupational engagement was subjective to their life roles and environments (see Appendix 5 for an example of the Activities Clock). Upon the participants having completed their Activities Clock, the researcher discussed with each participant their specific allocation of time per activity that they had listed in their Activity Clock.

3.11.3. Participant Observations

In qualitative case studies, researchers usually immerse themselves in the research, this is different from other forms of research, where researchers distance themselves so as to remain objective (Hancock & Algozzine, 2009). With participant observations, as part of qualitative research, the researcher participates with participants whilst observing at the same time (Creswell, 2014). Participant observations occurred 3 times a week, each session for a duration of 2 hours, over the period of 6 months. The observations took place at various times of the day, including over weekends, during breakfast, lunch, or supper, when medication was administered after breakfast and at random times of the day in the ward. Written observations were recorded in the researcher's field notes. The researcher observed the behaviour of participants whilst participating with them in the environment of the pre-discharge ward. Attention was paid to contextual conditions that were regarded as highly-relevant to the occupational engagement of female MHCUs (Yin, 2009). Factors such as mannerisms, social and emotional climate, social interactions, verbal and non-verbal forms of communication, interactions with staff and fellow MHCUs, norms and the shared experience of engaging in the tasks and activities in the pre-discharge context was observed and recorded on field notes (Creswell, 2014).

Participant observations contributed to an important additional piece of information that contributed to answering the research question. They captured unspoken, non-verbal cues, gestures, mannerisms, behaviours and actions which provided valuable insights into the emotional climate in the pre-discharge ward. These were closely observed whilst participating alongside female MHCUs in the ward environment as they went about their daily routine. As far as possible, the researcher participated with participants in the activities listed in the programme of the pre-discharge ward - whilst observing. The researcher participated in activities in the ward programme in the capacity of a researcher. Some of the activities included sitting and watching television with the participants in the time that was allocated for relaxing or engaging in informal conversations with participants during time allocated for leisure. The researcher also participated in setting the table during kitchen duties, as one of the activities allocated on the programme in the pre-discharge ward. It offered a chance to obtain unique insight into the explicit and subtle enablers and barriers to occupational engagement (Iacono, Brown & Holtham, 2009). Participant Observations corroborated with previous data sources including the Activities Clock and

document analysis (done with the programme in the pre-discharge ward) - together aiding in developing a deeper understanding of the occupational engagement of female MHCUs (Yin, 2009).

Zach (2006) warns against one of the pitfalls of participant observations being that the participant could alter the exact behaviour at the time of observation of the participant. However, importantly participant observations allowed the researcher to gain valuable insights which she would not had been able to gain, had she distanced herself. In addition, participating whilst observing provided the researcher the opportunity to gain a true understanding of the environment in the pre-discharge ward.

3.11.4. Interviews

Interviews in qualitative case studies were used to gather textual information from MHCUs, which were important to understand when building the case (Hancock & Algozzine, 2009). Interviews were face-to face (Yin, 2009), in-depth and semi-structured. Each interview lasted between 45 to 60 minutes. The interview questions were open-ended which ensured that participants were able to construct their own meanings regarding whatever arose through conversation and interaction with others (Creswell, 2014). The subjective meanings of MHCUs were understood to be embedded within historical and cultural practices (Frank & Murrithi, 2015). This meant that each participant was understood to be unique in their perspective and the way they perceived their occupational engagement in the pre-discharge ward (Creswell, 2014). Interviews involved personal interactions between the researcher and MHCUs. They required a certain level of trust and rapport that the researcher developed throughout the research process in the capacity of a researcher (Kielhofner, 2006). During the interviews the researcher listened attentively, her body language communicated openness and transparency, she explained that interviews were being recorded. MHCUs were offered a cup of coffee to enjoy whilst being interviewed - something she would not have done as a clinician, thus also delineating her the role as the researcher from that of the clinician. The researcher created an environment that was predictable, relaxed and private in which to encourage the sharing of information.

Interviews took place in a building separate to the ward, still on the hospital premises though. This served to also delineate the researcher role from the clinician role. Interviews were carried out in a room that was private and quiet and so conducive for interviews. The interviews were recorded using a Dictaphone and were later transcribed verbatim (Creswell, 2014). The morning was selected as a suitable time to conduct interviews as participants would be awake and alert and not yet have endured the side effects of the medication. Some psychotropic medication side effects include drowsiness, slurred speech and psychomotor slowing. Interviews were transcribed

immediately after the first interview, which were used to informed second interviews respectively. Interview questions were designed in layman's terms that participants could easily understand and in also the language of their preference. Two out of the five participants' home languages were IsiXhosa, both participants were fluent in English and preferred to conduct the interview in English. Both participants were informed at the time of recruitment about translation services that were available to them and that the collection of data could be done in the language of their preference. Both, however, chose to conduct the interviews in English.

3.11.4.1. First interviews

At this stage of the research, data had already been collected from the Activities Clock and the programme in the pre-discharge ward. First interviews were conducted with each MHCU; the first interview occurred whilst participants were in the pre-discharge ward so as to understand the personal perspectives (Yin, 2009) of MHCUs about their occupational engagement whilst in the ward. Questions included: *"tell me about your routine in hospital, in the pre-discharge ward. Tell me about the things you do in the ward? What are the things that you enjoy doing? Which gives you meaning in your life?"* (see Appendix 6). These questions addressed the objective of describing female MHCUs views of what occupational engagement entails in the pre-discharge ward. First interviews occurred after participants were assessed by the treating MO as being euthymic and without psychosis. The outcome of the assessment rendered MHCUs as clinically stable and capable of making autonomous decision for or against participation in the research. After the initial interview was conducted, data were transcribed (Creswell, 2014) and analysed immediately, keeping the research question in mind. Data was collected and analysed simultaneously, which was important for building the case. To strengthen the case, a second round of interviews were conducted.

3.11.4.2. Second interviews

Second interviews were arranged and occurred on the same day as the MHCUs follow-up appointments two weeks post-discharge. Holding the interviews on the same day as their appointment made it more convenient and cost effective for the MHCUs. These follow-up appointments took place at the facility's outpatient department (OPD). At the time of second interviews, participants were reassessed by the MO. By completing the mental state examination (MSE) all participants were reassessed as being without psychosis, euthymic, and adherent to their medication regimes. With this they were declared as being clinically stable and capable of making an autonomous decision for or against participation in the second interview. The researcher, in the second interviews, created the same environment as in the first round of interviews. Once again MHCUs were given the choice in which language they preferred the

interviews to be conducted. An interpreter was made available. MHCUs again preferred to have the interviews in English.

Questions that were asked in second interviews were: *"tell me about your experience of being in the pre-discharge ward"* (see Appendix 7). This open-ended question speaks specifically to the objective that was to explore MHCUs perspectives of the pre-discharge ward environment. "*Explain the duties patients had in the ward and what do you think was the purpose of these duties?"* This question was based on data received from the first interviews that required more depth in building the collective case. The question specially addressed the objective to describe MHCUs views of what occupational engagement entails in the pre-discharge ward environment. *How is being at home different to being in hospital?* Here MHCUs were able to compare and list similarities and differences in their occupational engagement in the pre-discharge ward with their occupational engagement when they were discharged. The questions asked in both first and second interviews above collectively aimed at answering the research question and strengthening the collective case. Data were collected in the second interviews until the point at which similar themes recurred indicating that data saturation was achieved.

3.12. Data Management

Hard copies of the consent forms, Activities Clock and notes related to research were retained in a lever arch file that was protected in the researcher's office. Transcribed data was stored on password-protected computers for safekeeping. Data was only accessible to the researcher, supervisor and transcriber to ensure confidentiality and protection of participants. The researcher, in her undergraduate research, had carried out qualitative data verbatim transcriptions and was familiar with transcribing data. However, the researcher observed that transcribing was time-consuming and delayed her ability to engage in other research-related activities. The researcher therefore employed a transcriber. The transcriber was recommended by a peer who the transcriber had previously assisted. The transcriber had been trained in transcribing for academic purposes and did not require additional training. She was contracted to the research and her employability was subject to completion of a confidentiality agreement to uphold ethical duties of confidentiality and non-maleficence; this included an agreement that the transcriber discard the verbatim recordings and transcripts upon their completion. This was was an agreement reached between the researcher and the transcriber. This agreement was upheld, and proof of the deleted data was sent to the researcher at the completion of data transcription. Data shall be kept by the researcher for the duration of three to five years and will remain the academic property of the University of Stellenbosch. Confidentiality was maintained and the participants' identities were protected throughout the research process. Additionally, the identities of participants were protected by using pseudonyms to label transcribed data (Anney, Dar, & Salaam, 2014). Data

was also managed on Weft QDA (qualitative data analysis software). This is a tool used for the analysis of textual data, such as interview transcripts, in qualitative research field notes and documents. Accurate transcription was crucial during the research process. It was the process, which was theoretical, selective, interpretive, and representational (Davidson, 2009).

3.13. Multi-phased intensive data analyses

All data collected from the four data sources (programme in the pre-discharge ward, Activities Clock, field notes from participant observations and transcribed data from interviews) contributed to the building of the case. The findings from all data collected from these sources was analysed. Multiple perspectives of the collective case strengthened the case of obtaining a greater understanding of the occupational engagement of female MHCUs in the pre-discharge ward. Multi-phased intensive data analyses were used to analyse the data. Themes emerged from inductive analysis. After the themes were formed, the researcher matched each case with the formulated themes before a comparison across the cases was completed. Four analytical strategies were utilised respectively (thematic, content, within-case, and across-case analyses).

The analytical strategies abetted the researcher in comprehending the construction of meaning by female MHCUs in the occupations that they engaged in, in light of their social and historical (Law et al., 1996) worldviews, respectively (Creswell, 2014). The researcher immersed herself in the data by reviewing and familiarising herself with the transcripts, which was important for the analysis (Bell, 2010). Joffe & Yardley (2004) explain that inductive analysis should be used when literature reveals that no previous studies dealing with the phenomena being studied exist. A method of inductive analysis was used to analyse data to generate new ideas (hypotheses), since no previous studies were found - unique to South Africa - to have been conducted on the occupational engagement of female MHCUs in a tertiary psychiatric facility. Multiple analytical strategies of intensive data analyses made-up a powerful case, since it permitted for data to be analysed within cases (within-case analysis) as well as across cases (cross-case analysis) (Yin, 2009). Interviews and field notes were analysed in phase 1 and 2, using within and cross-case analysis (Yin, 2009) and categories and themes were generated using thematic analysis (Bloor & Wood, 2006; Braun & Clarke, 2006). The Activities Clock and programme in the pre-discharge ward was analysed in phase 3 using content analysis (Hancock & Algozzine, 2009; Roberts, Wang, Brzosowicz & Jong, 2019). Phase 4 involved the re-construction of and convergence of data from all data sources across all cases.

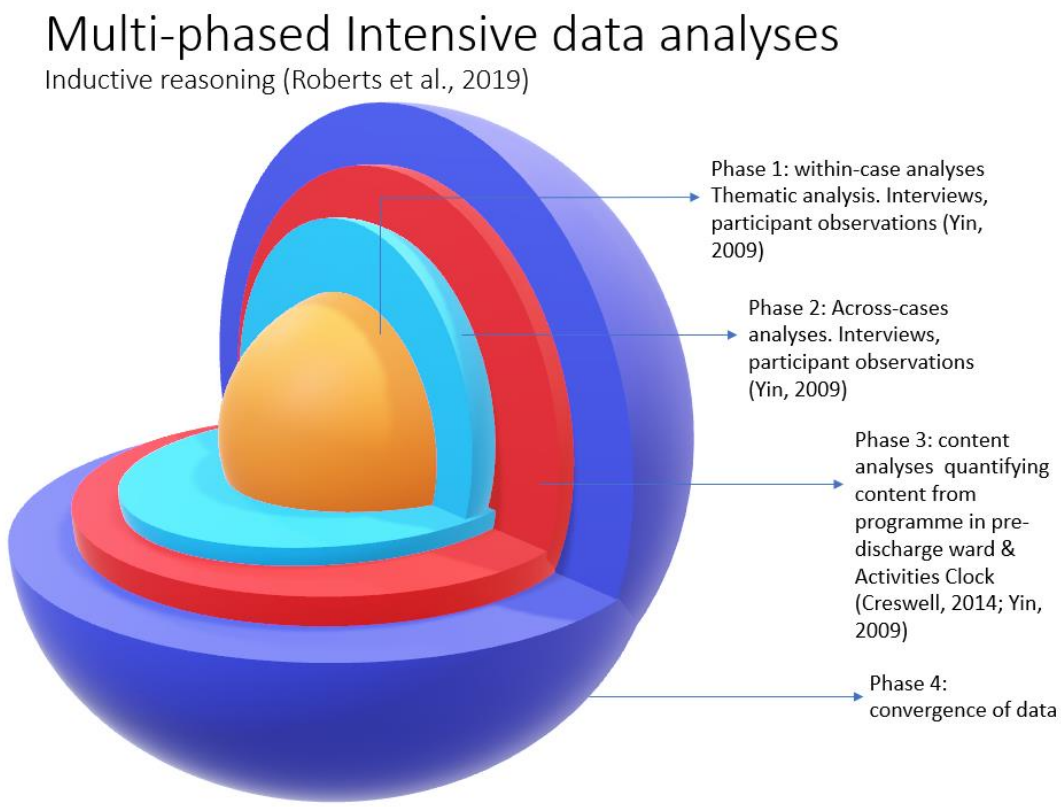


Figure 10 - The multiple analytical strategies.

3.13.1. Phase 1: within-case analyses

In the 1st phase of analyses, transcripts were imported into the WEFT QDA software and then into word and excel spreadsheets. Data from interviews and field notes were used in both phases 1 and 2 of the data analyses (Yin, 2009). Open coding analyses was used, where each word and phrase was analysed line-by-line (Zach, 2006). Initial coding was done where similar phrases and words in each case was grouped together. Altogether two hundred and sixty-six codes were found after the first round of analyses. Patterns and trends that described the environment such as "*there is a monitoring one, where, let me just think, where a patient has to check fellow patients, whether they made their beds," "So, I just think we need more physical games that we can do with our hands uhm yah"* or *"it's like you are no longer a human being"* were some of the initial codes. Similar codes were categorised and placed into 30 categories and 15 sub-categories. These categories were important for building conceptual categories later. Data collection and analyses occurred concurrently; so, every time a new transcript was received it was analysed. Each transcript was analysed separately, both in WEFT QDA software as well as excel, where it was tabulated. After 12 rounds of within-case analysis 2 themes emerged.

3.13.2. Thematic analysis

Data from interviews was analysed using thematic analysis. Thematic analysis is a strategy of analysis used in qualitative case studies to generate meaning from the data (Hancock & Algozzine, 2009). Thematic analysis is used to detect patterns, clustering and plausibility (Hancock & Algozzine, 2009). As an independent method of analyses, it was chosen abetted for the identification and grouping together of similar and different trends of the occupational engagement of MHCUs. (Joffe & Yardley, 2004). Braun and Clarke (2006) described thematic analysis as a descriptive method; it would describe the occupational engagement and the environment in the pre-discharge ward. WEFT QDA is the software that was used to code and categorize the data. Open coding started with identifying similar words and phrases that described various viewpoints such as *"you could be doing more," "there's very little to do," "same thing over and over, I mean I can't do the washing. I used to do the washing on my own"* to be grouped together into a theme. After several rounds of thematic analyses, there were 4 themes and categories were narrowed down from the initial 3 categories with the corresponding 24 sub-categories to 2 themes with 9 corresponding categories.

3.13.3. Phase 2: cross-case analyses

In the second phase of analyses, data from the interviews (from phase 1's within-case analysis) was broken down into pieces and examined closely for similarities and differences in MHCUs viewpoints on their occupational engagement in the pre-discharge ward. Similar words and phrases were coded together to create a category across cases, which eventually was grouped into a theme (Yin, 2009). Selective coding was done across cases to find similarities and differences amongst MHCUs perspectives (Zach, 2006). Open coding was also used in this second phase of analyses that searched for similarities and differences across views of occupational engagement that were later colour coded and tabulated in word and then excel sheets. Some of the similarities found were *"Very horrible. Uhm it's basically, it's just uhm eat, sleep, medication," "It's like a, there's a shower, bath, shower, bath. Everybody in one bathroom, security can be sometimes very nasty uhm in a sense of."* Categories and sub-categories were further narrowed down to 2 themes that were closely linked to the objectives of the study (Baxter & Jack, 2008). Throughout the analyses in all phases and stages, the researcher frequently approached the research question's objectives to ensure that the analyses were appropriately aligned.

3.13.4. Phase 3: content analyses

The third phase involved content analyses. A methodical characteristic of qualitative content analysis permitted the researcher to combine analyses of the construction of meaning within the setting (Bloor & Wood, 2006). Documents (Hancock & Algozzine, 2009), such as the programme in the pre-discharge ward, were analysed using content analysis (Yin, 2009). The data collected from the content analysis done on the Activities Clock provided valuable information about the occupational engagement of the female MHCUs. The content analysis was further broken down into three stages (Figure 11). Activities (a) and tasks (t) were clustered in stage 1. In stage 2 of this phase, the amount of time spent engaged in activities (a) and tasks (t) were summed. In stage 3 of this phase the sum of (a) and (t) were divided by the sum of hours in one day (24 hours) to work out the percent of time engaged in occupations.

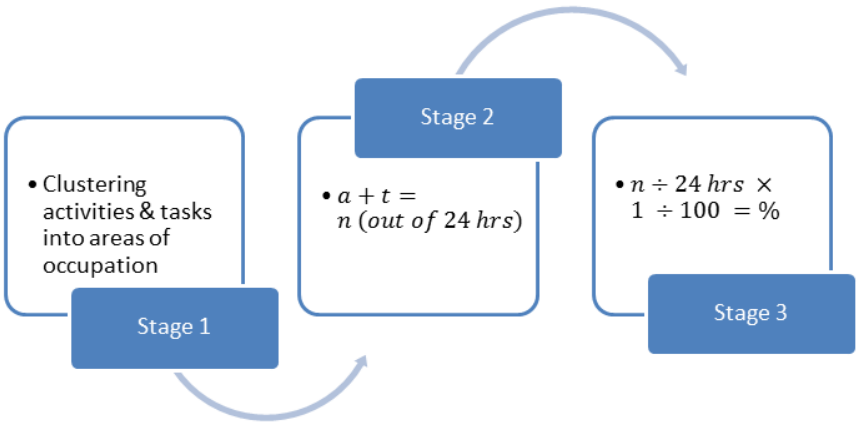


Figure 11 - Phase 3 of multi-phased data analyses, this included content analyses stages 1-3.

3.13.4.1. Stage 1: Clustering

Stage one involved clustering the various tasks and activities into the respective areas of occupations, i.e., BADLs (basic activities of daily living), and IADLs (instrumental activities of daily living), rest, sleep, education, work, play or leisure and social participation. This was an important step that was directly linked to the objective of describing MHCUs occupational engagement in the pre-discharge ward. In the programme in the pre-discharge ward, activities such as brushing teeth, face washing, bathing, dressing, taking medication, personal hygiene and therapeutic group activities were clustered together in the occupation of BADLs as part of the programme in the pre-discharge ward. Sitting, relaxing, and sleeping were classified as rest and sleep. Visiting in the ward, receiving and making phone calls, watching television and exercise were clustered into the

occupational area of leisure. In the Activities Clock, activities were classified differently for different MHCUs as various tasks and activities held different meanings for different MHCUs (American Occupational Therapy Association, 2014). Stage 1 of this phase of clustering of activities and tasks in various occupational areas was done for Activities Clock, though here as mentioned, the clustering into the various occupational areas was subjective according to the meaning it held for MHCUs (American Occupational Therapy Association, 2014).

3.13.4.2. Stage 2: Applying the formulae

Stage two of content analyses involved applying the formula to the allocated times per occupation. This occurred for both the content of the programme in the pre-discharge ward as well as the Activities Clock. The formula used was $a + t = n\ (out\ of\ 24\ hrs)$. In stages 2 and 3, the amount of time spent on various types of tasks and activities as part of the programme had been calculated.

3.13.4.3. Stage 3: Percentage of time

Stage three then involved calculating the percent of time engaged in the various occupations, using $n \div 24hrs \times 1 \div 100 = \%$. Where *n* is the amount of time engaged in a specific task or activity. This was divided by 24 hours in a day and then multiplied by 100 to get the percentage of time spent engaged in various tasks or activities in the ward as part of the programme in the ward. In the Activities Clock, the formula was used to work out the amount of time spent engaged in the various activities that were meaningful to MHCUs (American Occupational Therapy Association, 2014).

3.13.4.4. Phase 4: Convergence of data

Each data source contributed to building the case and each source contributed to a greater understanding of the case. Together it adds strength to the findings, as various strands of broken-down data are braided together to promote a greater understanding of the case (Baxter & Jack, 2008). In phase 1 of within case analysis, individual cases were analysed separately. In phase 2, analyses occurred across the cases, where similarities and differences were noted. In phase 3, the types of activities were clustered in areas of occupation and the amount of time engaged in the activities was calculated using the content analyses for both the programme in the pre-discharge ward and the Activities Clock. All the phases above were directly linked to the objectives of the study and double-checked to describe the views of the MHCUs occupational engagement and their perspectives of the environment in the pre-discharge ward. Once all data was analysed from the programme in the pre-discharge ward and the Activities Clock, from the interviews as

well as the field notes from the participant observations, the pieces were fitted together like a puzzle. Information from all the data sources listed above contributed to answering the research question and building the case. As offered by Yin's (2009) approach to case study research, the cross case-analysis contributed to the identification of similarities and differences of themes and relationships (Yin, 2009). Findings from the four data sources were checked against each other so as strengthen the case (Creswell, 2014; Yin, 2009).

3.14. Quality of the research

The quality of the research in the present study was ensured through checking it against standards of credibility (Krefting, 1991), confirmability, transferability, and dependability. These four standards used in qualitative research ensured trustworthiness and rigor of the research. The strategies are detailed below (Li, 2004; Roberts et al., 2019).

3.14.1. Credibility

The researcher presented transcribed data to MHCUs for member checking. Once all interviews were transcribed the researcher contacted participants to verify that the information that had been captured was correct. MHCUs were presented with the transcripts from their interviews for validation that transcripts captured, were true reflections of the content discussed in the interviews. Triangulation was ensured using multiple data sources such as the programme in the pre-discharge ward, the Activities Clock, participant observations and interviews, which contributed to a robust case. This was followed by the phased analytical strategy, within-case and across case analyses, content and thematic analyses. Multiple data sources and multiple analytical strategies (Yin, 2009) contributed to the credibility of the findings (Maher, Hadfield, Hutchings, & De Eyto, 2018; Roberts et al., 2019).

Data were collected at different time intervals over the period of six months and was determined by the average length of stay of MHCUs at the facility. Person triangulation was ensured by collecting data from different MHCUs, which informed the collective case. The researcher was immersed into the research. The prolonged engagement ensured that the researcher developed a deeper sense of understanding of the case. With the researcher being a clinician at the facility, she was aware of the potential conflict of her roles of clinician and researcher (Maher et al., 2018). The researcher ensured delineation of her role of researcher from that of clinician - ensuring that they did not overlap. This was an important task in ensuring the credibility of the research. Some of the practical aspects employed that were used to delineate the roles of researcher and clinician were that interviews occurred in a different venue from the pre-discharge ward. During interviews the researcher was dressed in civilian clothes and shared a cup of coffee with MHCUs. The

researcher collected data, via interviews and participant observations over the weekend, which was outside of usual clinical times in the pre-discharge ward. These practices did not form part of her everyday practice as a clinician in the pre-discharge ward, which separated the role as a clinician and a researcher.

The researcher was cautious about developing her own constructions (Baxter & Jack, 2008). Reflexivity was practiced through journaling her role, thoughts, viewpoints after every encounter with MHCUs so as to mitigate this risk of bias. The researcher employed this bracketing to ensure that her biases were made explicit and communicated to her peers in the Master in Occupational Therapy Advisory Sessions (MTAS) and with her supervisor (Baxter & Jack, 2008). Field notes were taken after every encounter with participants. Field notes were recorded in the researcher's personal research journal (Zach, 2006). An observation guide was used in order to collect data on date, time, location, list of features being observed, specific activities and events related to the research question and objectives, and initial impressions of the activity were recorded (Hancock & Algozzine, 2009).

This study was presented to a group of researchers who were not involved in the study, to peers in a technical support group for master's students. Input was provided and integrated herewith, for peer review (Baxter & Jack, 2008). Monthly supervision meetings between the supervisor and researcher ensured peer review. Peer debriefing and review, member checking, prolonged engagement, and triangulation, strategies ensured that the research conducted was credible.

3.14.2. Confirmability

Confirmability refers to the degree to which the results of a study can be verified by other researchers (Anney et al., 2014). The findings of this study were confirmed by fellow researchers in the field such as Jack et al., 2014; Lindgren et al., 2018; Mayers et al., 2010; Pelto-Piri et al., 2019; Smith et al., 2014. Confirmability for this study depends on whether the data used was real data derived from participants and not fiction of the researcher's imagination (Anney et al., 2014). Member checking was hence used to confirm the findings with the MHCUs. An audit trail of data analyses, using both WEFT QDA and manual coding, all data transcripts, interview guides, consent forms, information letters and all research-related activities was documented, filed and made available for review. The use of multiple data sources including the Activities Clock, the interviews, the programme in the pre-discharge ward and participant observations allowed for checking for corroboration and convergence of the data. The multi-phased analytical strategies (Baxter & Jack, 2008; Yin, 2009) allowed for checking of convergence, contributing to the confirmability and dependability of the findings of this study (Anney et al., 2014; Maher et al., 2018; Zach, 2006).

3.14.3. Transferability

Transferability refers to the degree to which the research can be transferred to a different context (Anney et al., 2014; Baxter & Jack, 2008; Zach, 2006). To this end in this study, an audit trial of all research-related activities was recorded. The explication of the qualitative case study design that detailed the bounded case as the occupational engagement of female MHCUs in the pre-discharge ward of a tertiary psychiatric facility in the Western Cape of South Africa, ensured transferability. A detailed and thick description of the study context (3.6) and study population (3.7) in the pre-discharge ward and thick description was provided. Purposive sampling strategies using selection criterion were detailed and then demonstrated (3.10). A systematic description of the recruitment process - which could be used to apply the research to a different setting - was provided (Zach, 2006). Data collection and analyses was detailed into phases and various stages, followed by diagrammatic representation and formulae for further explication, making transferability plausible (3.11) (Hancock & Algozzine, 2009). Formulae and step-by step explications for content analysis were provided. The use of thick descriptions of the case, data collection methods and of the multi-phased data analytical strategies used was provided - collectively contributing to the transferability of the case study.

3.14.4. Dependability

Dependability refers to the firmness of the findings of a study over a period of time (Roberts et al., 2019; Anney et al., 2014; Baxter & Jack, 2008; Zach, 2006). Dependability in this study was ensured through audit trails, reflexive journaling, multiple data sources and multiple data analysis strategies. Throughout the study, the researcher and her supervisor held meetings pertaining to every process of the research for consultation and guidance. Good record keeping of data collection and data analyses was ensured including that of transcripts, interview guides, participant observations (field notes) and all other research-related activities. Reflexive journaling was used to bracket the researcher's feelings and thoughts throughout the research process (Creswell, 2014). Member checking was done after interviews. All research-related activities were detailed in the present study. Formulae were provided and then demonstrated using charts and diagrams as far as possible. As part of content analysis, formulae were used, since it was a more dependable method, which had a dependable outcome of measurement. In addition, part of the selection criterion was that MHCUs had to be assessed by their treating MO as without psychosis and mentally stable before they were recruited to the study. All MHCUs were mentally stable and without psychosis at the time when their interviews were conducted. The fact that MHCUs were in a mentally stable state when they provided information also ensured a greater dependability of data provided.

3.15. Ethical considerations

Ethics in health research is absolutely crucial, especially when conducting research for humans (Neale & Hanna, 2012). These ethics are moral principles and standards that a research study is required to adhered to in order to protect the participants of the study from being harmed. Neale and Hanna (2012) explain that ethics requires the application of moral rules and professional codes of conduct to the collection of data, the analyses thereof and the reporting of results. It also requires the respecting of the right to privacy and confidentiality of the research participants (Neale & Hanna, 2012). This study adhered to the ethical principles of non-maleficence, autonomy, justice, beneficence and confidentiality which are guided by the Declaration of Helsinki of 2013 (Neale & Hanna, 2012). This study obtained ethical approval from the Higher Research Ethics Committee (HREC) of Stellenbosch University. The approval number for this study is S17/10/220. The study also obtained ethical approval from the Western Cape DoH (Department of Health) for conducting research at and gaining access to female MHCUs at a government tertiary psychiatric facility - a necessary step also to securing the permission the researcher needed to access to participants, the female MHCUs at a tertiary psychiatric facility in the Western Cape of South Africa.

3.15.1. Non-Maleficence

Non-maleficence refers to not doing any harm to participants. It was ensured that no physical, emotional or psychological harm was done to the MHCUs and no procedures as part of this study was invasive to their states of being either. The researcher advertised the research to MHCUs and waited for them to express interest in the study. To this end she pasted a poster up on the wall in the pre-discharge ward. She also asked the operations manager to announce the study and the fact that she was looking for participants in the ward. Recruitment for study participants occurred only as MHCUs displayed interest. Willingness to participate cued the researcher to go ahead with the recruitment process. The recruitment process was done in a phased manner as explained in section (3.10) of this thesis.

MHCUs are classified as a vulnerable group of people that needed to be protected (WHO 2011). According to Appelbaum (2007), mental illnesses such as schizophrenia and bipolar can impact the capacity to make decisions. Appelbaum (2007), however, also affirms that capacity is situation specific, which means that capacity for various tasks must be assessed per situation. According to Appelbaum (2007), any health professional can assess a MHCUs capacity to make decisions in the following manner: by assessing the MHCUs capability to communicate a choice, to comprehend the relevant information and to appreciate the consequences to the preferred decision.

MHCUs who expressed interest in the study were screened and assessed for capacity to give consent to participate in the study. MHCUs who were assessed as not having capacity to consent were excluded from the study, thus protecting them from exploitation. MHCUs who were assessed with positive capacity to consent were then assessed by the treating MO on their mental states. The outcome of their MSE had to render them mentally stable and without psychosis before they were recruited to the study. Once it was established that MHCUs were clinically stable with positive capacity to consent, they were then handed the information and consent forms. Due to the fact of having been screened for having a positive capacity to consent, and as they showed capability to comprehend the research and to appreciate the implications of being participants in the study, this rendered them able to consent to the study. It was the researcher who handed the information and consent forms to MHCUs. She also explained the research in layman's terms and answered all questions that they had about the study, in the language of their choice. Thus, ensured that MHCUs were fully aware of what was expected of them during their participation in the study.

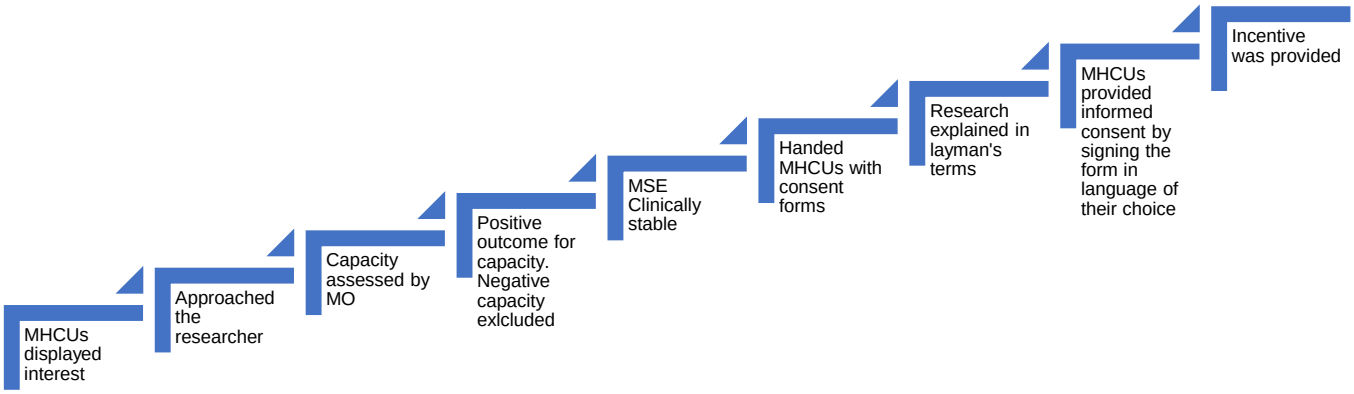


Figure 12 - The step-by-step process of obtaining consent.

Information and consent forms were made available in three of the official languages of South Africa, English, Afrikaans and IsiXhosa (see Appendix 8). These three languages were the most common languages that the MHCUs conversed in within the pre-discharge ward, hence the choice of these three languages out eleven official languages. MHCUs were able to choose which

language they preferred from the languages listed above. An IsiXhosa interpreter was available for interviews to ensure that MHCUs could express themselves in the language of their choice. Two out of the 5 participants' first languages were not English, both however were proficient in English and chose to read the information sheet and complete the consent forms in English. One of the 2 participants was an English interpreter. All MHCUs chose to have their interviews in English. Throughout the research process, the researcher asked participants and reminded them about the translation services that were available, but none were requested.

The dual roles of researcher and clinician that the researcher was playing in the ward were noted as being potentially conflicting roles that could potentially impact on biases as a clinician and a researcher. The researcher therefore referred her patients that had enrolled in the study to another Occupational Therapist in the pre-discharge ward - thus ensuring that no harm was thus be done to these MHCUs as a result of her dual roles. In addition, a concerted effort was made to separate the roles. This also demonstrated practical wisdom and ensured that the rights of MHCUs were protected. MHCUs were aware that they had the right to withdraw at any point of the study, without enduring any consequences, thus upholding the ethical principle of non-maleficence. Moreover, the researcher also informed participants that they reserved the right to decline to participate in the research and assured them that their declining and upholding their right to withdraw from the study at any given point would not have negative consequences and would not impact negatively on their management plans on the ward (Neale & Hanna, 2012).

3.15.2. Autonomy

Autonomy refers to participants making their own decisions regarding what to do and what they agree to do (Neale & Hanna, 2012). In this regard, MHCUs were not coerced to participate in the study. Care was always taken to respect the autonomy of MHCUs. Interest to participate in the study was an important reservation of choice of MHCUs that the researcher reserved in the present study. Since MHCUs were certified under the MHCA, their autonomy was compromised by their certification. An example of this was that they did not have a choice as to which interventions they wanted to participate in. According to the MHCA 17 of 2002, MHCUs who were certified under the Act, mental health interventions was mandatory for them to participate in. Hence interest to participate in this study was an important reservation of MHCUs autonomy. MHCUs were informed that they had free will (Orb, Eisenhauer & Wynaden, 2000) with regards to whether to participate or not.

3.15.3. Justice

Justice in health research studies is governed by three ethical principles: first, respect for persons, (Mastroianni, Faden & Federman, 1994), that people should be treated as autonomous beings and that people with limited autonomy should be protected (Mastroianni et al., 1994). In this study care was taken to always treat MHCUs with respect and to uphold respect for and protect their rights. The second principle of justice is beneficence; this is the obligation to maximize possible benefits and minimize possible harms in the research (Mastroianni et al., 1994). With regards to benefits to MHCUs, this study offered the immediate benefit of a gift as a token of appreciation and the possible benefit to future MHCUs in the pre-discharge ward. There were no risks involved in the execution of this research. No physical harm was caused, and no invasive procedures occurred and no harm was done to MHCUs in this research. The third ethical principal of justice, distributive justice, refers to the appropriate representation, which applies to classes of people rather than individuals. (Mastroianni et al., 1994). This study included a variety of age groups, ethnic groups, racial orientations and socio-economic groups. This study was not limited to a particular ethnic group, racial orientation, or socio-economic group.

Furthermore, a fitting match is one aspect of justice that refers to the population from which research subjects are drawn. The study population should reflect the population to be served by the foreseeable research outcomes. All potential participants were presented with a fair opportunity to participate in the study. In this study, MHCUs, that would be admitted in the future to the pre-discharge ward, would be the beneficiaries of the research outcomes, through the extrapolation of recommendations to the programme in the pre-discharge ward. Justice in health research also refers to previously-oppressed groups of people in society to have a place in studies, that are likely to benefit members of the group being investigated. The research participants in this study, female MHCUs were both vulnerable and previously- oppressed by having been exposed to some form of abuse in their lifetime prior to their admission. This study provided the opportunity for their voices to be heard.

3.15.4. Beneficence

Beneficence refers to the reasonability of the risks in relation to the potential benefit of participating in the study (Neale & Hanna, 2012). Upon recruitment, consent forms were completed in the preferred language of choice of MHCUs. An immediate benefit for MHCUs who participated in the study was that they received an incentive for participating. This was not a coercive measure but rather a kind gesture that showed appreciation for their choice of participating in the study. MHCUs were moreover thanked by the researcher for participating. The

aim of the study would ultimately be to benefit future MHCUs in the pre-discharge ward by improving the ward's programme through the extrapolation of its suggestions and recommendations. MHCUs in other settings might also possibly benefit from this research, since it advocates a for quality health service that is responsive to the needs of MHCUs in similar settings.

3.15.5. Confidentiality

Several data management measures were employed to ensure confidentiality. Pseudonyms were used for the participants so as to ensure that their identities were protected. The transcriber signed a confidentiality agreement for the study. Transcribed data from the transcriber including recordings and transcripts were deleted upon completion of scripts (see data management at 3.12) (Neale & Hanna, 2012). All data (field notes, recordings, and transcripts) were stored on password-protected computers for safekeeping.

Overview of chapter three

In chapter three the epistemology was delineated within a constructivist paradigm (Creswell, 2014). The study used a qualitative approach and collective case study design that investigated the occupational engagement of female MHCUs in the context of the pre-discharge ward (Yin, 2009). Purposive sampling was used to recruit participants and made up the collective case. Multiple data sources with corresponding multi-phased intensive data analyses strategies were employed herein. Inductive reasoning was utilised to analyse data, which was strategically analysed through thematic, content, within-case and across-cases analyses respectively. Strategies that ensured a high quality of the research were explicated, including those of credibility, confirmability, transferability and dependability. Ethical principles and their application in the present study were detailed. The findings will be presented in chapter four of this thesis.

CHAPTER FOUR

4. FINDINGS

Figure 13 - The structure of the presentation of the findings.

Introduction

In this chapter the themes and categories are tabulated. A case-by-case description of the occupational engagement of female MHCUs is then presented individually and, following this, as a collective. Within-case explications are tabulated per case. Similarities and differences are then drawn across the cases (Yin, 2009). The themes emerged from inductive analysis. The researcher then matched each case with the formulated themes before a comparison across the cases was completed. Findings from the content analysis of pre-discharge ward programme are presented in a pie chart. The findings of the content analysis of the Activities Clock are represented in pie charts, per case, and can be found in Appendix 9.

4.1. Themes and Categories

Theme 1 This is not a prison it's a hospital	Uhm it's basically eat, uhm sleep, medication
	I must take my clothes off in front of so many women
	You must keep your mouth
	We need to line up
	Monitoring on your section
	Sitting the time out
Theme 2 We need to do more	You could be doing more
	Preparing a meal for my family, that's what I do
	I enjoy cleaning, it's a hobby but you can't clean in hospital

Table 3 - The themes and categories.

4.2. Case by case description

Charmaine

"Sitting the time out"

At the time of the study Charmaine was a 32-year-old single mother of one child. Upon admission she was diagnosed with bipolar disorder. Before hospitalisation she had used substances and was exposed to intimate partner violence. At the time of the study Charmaine was fulfilling a 3-month admission in the pre-discharge ward. This was her third readmission. Charmaine had been previously employed as a cashier at a local shop in her community; she described having really struggled with interpersonal and problem-solving skills at the workplace and left due to relapse. Nevertheless, she aspired toward employment but was disheartened by the stigma of her mental illness and lack of available opportunities in her community. She mentioned that everyone in her community knew that she was a patient at the psychiatric hospital and that people, even younger children, laughed and stared at her when she accessed the support group programme in the community. She explained that as a result she had not returned to it because she felt ashamed. Nevertheless, Charmaine was a church-goer who believed in the power of prayer. At church she found comfort in the message of God. Charmaine attended her follow-up appointments with the doctor and was assessed as euthymic, without psychosis, adherent to her medication regime and mentally stable.

In her interviews during and following her admission Charmaine explained that there was very little for her to do in the pre-discharge ward. Sometimes she felt that she would like to take the broom and sweep but there was a cleaner employed in the pre-discharge ward.

For me it was, there's very little to do, there I can't just take a broom and sweep or take a mop and mop up if I messed or something because that is somebody else's job and watching television was okay…[Charmaine]

Watching soaps on television for two hours every day was not the most effective time-management technique, as reported by Charmaine. She claimed that one could do so much more in two hours. Aside for the OT and Physiotherapy therapeutic groups, there was still a large

amount of time that participants felt was under-utilized in the pre-discharge ward and reportedly indicated that it was not a true reflection of how their time would be spent after discharge.

If you are sitting like for 2 hours in front of the television, you are going to get bored because you watching the soaps like it's the same thing over and over and it's like days of our lives, if I switch on days of our lives now I'm going to be caught up, I'm going to be caught up on what I lost like for 2 months, I'm going to know exactly what's going so yah, it's like that. [Charmaine]

I'm in front of the television and I'm watching the soaps at home, I'm going to watch soaps for 2 hours. There was lots of time on your hands and, there was OT and there was physio but there was still a lot of time. [Charmaine]

Charmaine explained that she was motivated to engage in additional activities; however, there were not enough opportunities for meaningful occupational engagement in the pre-discharge ward. She really enjoyed the occupation-based groups, though these only occurred once a week with a small number of MHCUs that attended. Charmaine also expressed that there were too few activities in the pre-discharge ward and that the programme was repetitive, which left her feeling bored. She recommended putt putt as an activity to have in the ward; she mentioned however, that she had never played it, though she was willing to learn how to play it.

And then we have to get up and then we just have to sit in front and do nothing. [Charmaine]

Charmaine explained that coming home from hospital was bittersweet. She was happy that she was leaving the hospital and going to be with her family again, yet anxious about how she would cope within and around her home, adapting to less structure. She explained that at times it was difficult to create her own structure when coming from a ward environment where the routine was rigid.

Because there are lots to do at home and yah. Like do the washing today, if we going to do the washing we going to be up at 7, you going to do the washing today, you going to have to hang,

you going to have to spin, you have to be there but now at, say now here, I can't just go in and go fold the washing and you know what I'm saying. [Charmaine]

At home she often found herself waking up at the time she woke up whilst in the pre-discharge ward but then she would thankfully think to herself that she was now home and would not have to adhere to the ward programme. Charmaine was grateful that at home she could shower independently, without other women staring at her whilst she performed her self-maintenance activities.

I have to get used to the fact that it's different because at home you can't just lounge around. [Charmaine]

Charmaine outlined that the rigidity of the rules within the pre-discharge ward that governed the times for bathing, sleeping, eating and medication even carried through with her after discharge. As a MHCU in the pre-discharge ward, Charmaine was so accustomed to the programme and its times for bathing, sleeping, eating and taking medication that when at home after discharge she found herself bathing, sleeping, eating and taking medication at those specific times. Charmaine indicated that she had little choice in the ward. All tasks and activities were compulsory, even if they did not have meaning to her.

But I could take my medication and I could lie down a bit and I could chill. 12h00 I'll have a sandwich or so and for me it was, here at hospital I must do everything at their time. I have to do everything according to what they say. [Charmaine]

I would think about, okay it's time for pyjamas, it's time for showering, it's time for doing this, and it's time for doing that according to the rules off the hospital like say like at 5h00 I have to be washed and dressed 8h00 it's breakfast time and you know there's a time for everything but at home I could say okay fine, no it's too early for breakfast, I could hold it a bit. [Charmaine]

Charmaine explained that in the pre-discharge ward they were given various duties to perform in the kitchen. Kitchen duty as reported meant that she was required to assist with setting the tables in the dining room before and after mealtimes. This involved placing the cutlery and plates on the tables and helping with the dishes in the kitchen after supper. Charmaine indicated that sometimes they allowed MHCUs to assist in the kitchen, but this was not a consistent practice. MHCUs sometimes had to be monitors in the ward, to ensure that fellow MHCUs were making up their beds neatly.

In kitchen duty you help with the breakfast you help put out the spoons, you help put out the plates. [Charmaine]

Charmaine explained that at home she was used to preparing her own meals and when she felt like having a cup of tea, she prepared it herself. Within the pre-discharge ward though, she could not prepare her tea herself. In the ward she felt restricted, without the freedom to prepare her own meals because the kitchen staff prepared the meals.

I can go to the fridge and open the fridge and make myself a sandwich, have a cup of tea but I couldn't do that here because here you are restricted. You have to wait upon the nurse to, you know? Do something and you have to wait upon the kitchen staff to give you a plate of food so yah. [Charmaine]

Preparing her own meals had meaning to Charmaine. Not being able to do so, at the time of her choice, in the pre-discharge ward, made her feel restricted. She reported that these activities held meaning to her as and at home she could choose when to do them so that they contributed to the structure of her day.

Charmaine voiced that when she was ill and admitted to hospital, she felt that she was missing out on too much back home and this impacted on various relationships with family and friends, especially her son. She felt as if her son was growing up without her and had formed motherly relationships with her sister and mother as a result of her being ill. About this, she expressed guilt and sadness.

I say, yoh [wow] I didn't even know you were pregnant and I see but I've really missed out on a lot, I really need to cut out this and that is when I draw the line and I said no, this stuff is not going do good because I see my cousin and I see her holding a baby girl and I see, but I didn't know you were pregnant and look here my cousin is getting married also. [Charmaine]

Charmaine indicated that her role as a mother was being impacted on whilst she was admitted to hospital. The things that she usually did for her child were being done by others during her admission. Her son was taken care of by others in her absence. Returning to her role as a mother after discharge was difficult because she felt as if she had missed out on too much in her relationship with her child.

Like my mommy say I must stop babying my son, I must stop babying him but then I say, I think it's because of time that I miss out on him, that bond that is between us, it feels for me, it's getting all smaller. [Charmaine]

Theme 1: "This is not a prison, it's a hospital"	
"Uhm it's basically eat, uhm sleep, medication"	X
"I must take my clothes off in front of so many women"	X
"You must keep your mouth"	X
"We need to line up"	X
"Monitoring on your section"	X
"Sitting the time out"	X
Theme 2: "We need to do more"	
"You could be doing more"	X
"Preparing a meal for my family, that's what I do"	X
"I enjoy cleaning, it's a hobby but you can't clean in hospital"	X

Table 4 - Within-case analysis for the case of Charmaine.

Ruwayda

"This is not a prison, it's a hospital"

At the time of the study Ruwayda was 30 years old, married and a mother of one daughter. Upon admission she was diagnosed with bipolar disorder. Prior to her admission Ruwayda had had a history of substance use and continued to endure intimate partner violence in her marriage. At the time of the study Ruwayda was fulfilling a 3-month admission to the pre-discharge ward. This was her second readmission. Prior to her admission she had experienced marital problems and sometimes felt like people did not understand her and her illness. When she was happy, people thought she was manic, it confused her and made her feel isolated from her family. Ruwayda, also mentioned that she loved her daughter dearly, but felt guilty for not being able to do things for her daughter and that her daughter was taken care of by her family. During her admission, she felt that her absence impacted on the mother-daughter relationship. When she returned from hospital, she would be excited to care for her daughter, but her family treated her as if she were not capable of caring for her daughter. Ruwayda was assessed by the doctor as euthymic, without psychosis and mentally stable.

In describing her time in the ward, the first thing Ruwayda highlighted was that the ward resembled a prison, with all the bars, locks and stainless-steel gates. She understood that some MHCUs required the containment but felt that it affected her mental health in such a manner that she felt unsafe. For Ruwayda, the routine in the ward was monotonous. The programme in the pre-discharge ward determined the routine of MHCUs in their engagement in basic activities of daily living (BADLs) of bathing, sleeping, eating, medication, PSR group activities, visiting hours, phone calls, mealtimes, etc. Ruwayda expressed her particular discontent towards the programme for what she felt that it created a rigid, structured, and restricted environment, particularly in the BADL.

…but they want to tell you, you can't dance, you can't do this, you can't do that, you can't do this, you can't make that, it's a hospital not a jail. [Ruwayda]

Yah [yes] I think, it's just the way, what's expected of you, it's just been put on you, you don't have a choice, if you want to bath with other people looking at you or whatever. It's like you are

just told to bath with other people or bath near people. So, everyone sees everybody naked and it's like you don't have a choice, you just, you need to. [Ruwayda]

Ruwayda expressed her dismay with the demeanour with which they were spoken to by the staff in the pre-discharge ward. MHCUs alluded to feeling victimised by the tone of voice, the pitch and the attitude when spoken to by some of the support staff working in the pre-discharge ward. Security in the ward were constantly passing comments at fellow MHCUs about their illnesses, a further unpleasant experience. It made her feel as if they were constantly being monitored.

The securities is like they, they like take the roles of the nurses and that man, they want to be the bosses and so but I don't, not right man, you can't, that's mos (actually) not their job man, their job is just to see if everything is in order and if there's no and keep the peace that's all. [Ruwayda]

Ruwayda exclaimed that when she was woken, she was required to tidy her bed. Tidying of beds was required to be completed in a way that was determined by the nursing staff. Upon completion thereof, beds tidied by MHCUs were then checked by the nursing staff and monitors in the ward to ensure that they met the standard set out by the nursing staff.

Nevertheless, you must wake up 5h00 the morning and you must go wash. You shower in the morning; after you shower, they say you must make your beds. [Ruwayda]

You must make your beds, make your bed right, bed must be made a certain way, so I make the bed and they make their beds, other patients make the beds and then they come check your beds. [Ruwayda]

MHCUs expressed their discontent with the repetitive routine in the pre-discharge ward. Additionally, they stated their views on the manner that the routine as part of the programme in the pre-discharge ward was implemented, that specifically the way they were treated, was demeaning and made them feel inferior.

What Ruwayda found demeaning was the fact that within the pre-discharge ward MHCUs used a communal shower to engage in bathing activities, which meant that all MHCUs had to shower at the same time, in the same shower. All were naked, and their bodies were exposed to each other and were monitored by nursing staff and security. MHCUs reported that they felt that, as humans and women, their privacy, and dignity were deeply disrespected in this practice. Ruwayda felt this so much so that it angered her. Additionally, the manner that MHCUs had to line up to wash, in a communal shower, made her feel deeply uncomfortable, although she mentioned that she was not ashamed of her body but that it violated her human rights and from a religious perspective it was unacceptable. Moreover Rudwaya felt that she couldn't express her unhappiness on this subject in the pre-discharge ward as she would be picked on by the staff, and her behaviour would affect the feedback given in the ward round, which could result in her stay being extended in the pre-discharge ward.

You know what makes me so horribly, terribly angry is the fact that I must take my clothes off in front of so many women and stuff, it makes me cross man and I can't take it. I don't like to; I like to wash alone man. I like my privacy, I'm not ashamed of my body, I have a nice body and everything, my body is, everything my skin, everything is right and whatever but don't like the feeling of washing in front of women and stuff like that man, it's almost like, how can I say, discouraging, is that the right word? [Ruwayda]

In the pre-discharge ward MHCUs did not have a choice to bath separately; the rules were rigid and had to be adhered to. Whether or not individuals felt that their privacy was invaded or not, the rules always applied to all. The rigidity in the programme in the pre-discharge ward created resentment amongst Ruwayda as well as amongst other MHCUs in the study, because they were not allowed to exercise choice in the execution of their personal hygiene activities in this regard.

In the pre-discharge ward, there were female security staff present. Security staff were contracted by the facility and worked in shifts. Ruwayda elucidated that she understood the reasons for having the security present within the pre-discharge ward as it ensured the safety of MHCUs and staff, that there would be no problems and that all MHCUs were adherent to the programme in the pre-discharge ward. However, she explained that the role of the security staff within the pre-discharge ward often became more than simply ensuring the safety of all parties in the ward. MHCUs felt that the attitude of the security staff in the ward made them afraid to express themselves. MHCUs also felt that the security staff influenced their engagement in the ward. Ruwayda felt that the security staff contributed to her feeling that she must tread carefully as she

and the other MHCUs were constantly being watched by the security. MHCUs felt uncomfortable and intimated by the security staff's presence in the pre-discharge ward.

The securities is like they, they like take the roles of the nurses and that man, they want to be the bosses and so but I don't know, not right man, you can't, that's not their job man, their job is just to see if everything is in order and if there's no and keep the peace that's all. [Ruwayda]

Apart from ensuring the safety of staff and MHCUs within the pre-discharge ward, Ruwayda claimed that the tone of voice, pitch and body language of the security staff communicated prejudice towards the MHCUs. Ruwayda and Carmelita both reported that they felt victimised by the security staff in the pre-discharge ward.

The security change shift and that security come on then you must keep your mouth and you must lower your tone. [Ruwayda]

Before any activity commenced as part of the programme in the pre-discharge ward, it was an expected norm for MHCUs to line-up. Ruwayda described that before mealtimes all MHCUs were required to stand in a line in the front of the door of the dining room before entering the room and were only allowed to enter the dinner room upon approval of the security staff. This practice occurred at all mealtimes, i.e., breakfast, lunch, tea and supper.

Then everybody must stand in the line, then you go into the dining room again where you had breakfast this morning then you have your lunch, after lunch like now, in this time that we are talking now its sleeping time. [Ruwayda]

Then its tea and bread you get and then you go to the dining room in a line again, you get your tea and bread and medication, your night medication, they call your names up again, give your medication one for one. [Ruwayda]

The same practice of lining up occurred when MHCUs received their medication. They were required to stand in a line, upon receipt thereof from the nursing staff MHCUs were to consume their medication in front of the security staff. This was to ensure that MHCUs took the medication.

Then they call your name up, they have a trolley then they bring it in front, front line, then they call your name out one by one to come get your medication in a cup and you must go fetch your water by security. Right, after that, after your medication you must go sit in front a little. [Ruwayda]

Participant observations of MHCUs in the pre-discharge ward confirmed that they were required to line up before eating, consumption of medication, upon receipt of their luxuries which were brought from home and upon bathing. Lining up was the culture in the ward and seemed to be an expectation of staff of MHCUs in the pre-discharge ward, which further created a sense of rigidity, fear and the comparison of the environment to that of a prison.

Ward staff appointed various monitors amongst MHCUs in the pre-discharge ward. The appointment of these monitors took place the climate meetings, which is when nursing staff meet with all the patients in the ward and do an individual assessment of them. Ruwayda indicated that the selection of monitors was not a consistent practice. The MHCUs in the ward were very uncertain as to the purpose of the assigning of monitors. The monitoring was viewed both in a positive and negative light which tied in with the comparison of the ward with a prison, in the constant need to be monitored.

Every Tuesday and Thursday it's climate meeting. Not every Tuesday. [Ruwayda]

Ruwayda, explained that she had been on kitchen duty before, where she had been required to assist with setting the tables in the dining room before and after meals, i.e., placing the cutlery and plates on the tables and helping with the dishes in the kitchen after supper. Kitchen duties, for MHCUs that were selected to carry them out, occurred for all mealtimes for the duration of one week. Once again MHCUs expressed that the selection of MHCUs for kitchen duties was not consistently practiced in the pre-discharge ward; at times it would occur as part of the climate meeting, but climate meetings were not always consistent and regular.

Say like me, I was on kitchen duty. You put out the breakfast, lunch, the supper and then nighttime, the teatime. At night from the morning you put out breakfast, the lunch and then teatime and then supper. [Ruwayda]

From participant observations and interviews, simply just sitting in the communal area in the pre-discharge ward and not doing anything was time allocated on the pre-discharge programme to rest and sleep. This seemed quite apparent to the participants because there wasn't anything else to do. After every activity on the ward programme, i.e., meal, group meeting, medication-taking, MHCUs were required to sit in front, in the communal area. In this time of waiting for the next activity to occur, whether it be mealtime, visiting time, or therapeutic group, it was clear that MHCUs were bored, unstimulated and unengaged and found themselves sleeping in their chairs. Upon entering one of the therapeutic groups some MHCUs would continue to sleep throughout the groups. It is such a common practice to sit and do nothing and wait. Upon completion of a therapeutic group MHCUs were required to sit and wait for the next group or break time, or mealtime as scheduled on the programme for the day. The environment within the pre-discharge ward was not stimulating for MHCUs towards occupational engagement; it was sedentary and restrictive.

Then we come back and then we sit whole time there in front waiting for breakfast. [Ruwayda]

By 7h00 we did. Then after that, then finish wash you, sit in the dining room 7h00 then you wait till 8:00. [Ruwayda]

The programme in the ward determined the routine and structure for MHCUs within the pre-discharge ward. It included basic activities of daily living (BADLs) as well as rest, sleep, education, and leisure. Ruwayda indicated that she was not entirely satisfied with the programme in the pre-discharge ward. She claimed that, apart from the therapeutic group interventions and watching television, she felt that there were more activities that MHCUs could be engaged in and expressed the need to be doing more in the pre-discharge ward.

For me it's, it's okay but, you could be doing more. [Ruwayda]

Then there's nothing to do but watch television or just sit there and yah. [Ruwayda]

Ruwayda explained that having nothing to do in the pre-discharge ward made her think about things that were irrelevant; it made her over think events in her life. Ruminating made her feel anxious.

It gives you time to think, you think a lot of nonsense, think what you going to do about this, think what you going to do about that, think all the onoorag [unnecessary] things, think all the unnecessary things man. [Ruwayda]

Ruwayda articulated that in the groups people discussed their various illnesses but there was still very little that they could do in the pre-discharge ward.

We discuss our illness but there's not basically much that I can say about the hospital that we do. [Ruwayda]

Ruwayda explained the meaning that cooking held to her. Ruwayda described that for her cooking held such a pleasant feeling in bringing the ingredients together into a dish for her family. In cooking, Ruwayda experienced a sense of accomplishment, which had a positive impression on her self-esteem and ultimately her mental health and identity. The process itself of preparing the ingredients required planning and organisation, which were cognitive functions. Preparing meals was not only about the product, it was also about the process. It was about what the experience what the cutting up of the vegetables, the measuring of the spices and the bringing it all together to create a product, had to offer participants.

I enjoy cooking number one it's very nice, it's very pleasant it's making things together, making, how I can say making food together, vegetables together and mixing things together for someone else for your family. [Ruwayda]

Ruwayda indicated that at home her days were filled with various tasks and activities related to home management and her caring for her daughter. These tasks and activities were also organised and planned according to her schedule that was centred on caring for her children. Ruwayda reported that these activities and tasks were what constituted her life when she was home but she was not engaged in these tasks and activities whilst in hospital, and specifically in the pre-discharge ward.

And then she will stay for an hour and a half and in that hour and a half I will make my supper time my supper one time and then tidy up also, wash her shirt out, clean her skirt that she had on for the day, she wears a skirt and shirt and I wash that out, her panty also and so, and her panty, she wears her school panty and wash all that stuff and hang it up and that is finish, she'll, I'll fetch her at madrasa [religious school]. Give her a snack or give her, if it's late already I'll give her supper one time, if it's 18:00 I'll give her supper and after that after that we'll come, when she comes home, watch television, I'll tidy up and as we were watching television we eating and then yah [yes]. Yah[yes] we lay in bed for a little while, play a little, basically my life is just about her, play a little, we don't go sleep late, say 21:00 22:00 side we go sleep, so that's basically my life. That's mostly my every day. [Ruwayda]

For Ruwayda, the routine of the programme in the pre-discharge ward was repetitive and rigid with few opportunities for input from MHCUs; she felt like it was not only restrictive but lacked meaning, in all its activities from meals to self-maintenance. The lack of meaningful activities in the ward left her feeling bored and she mentioned that there needed to be more activities for MHCUs. Simply doing nothing, according to her, left her too much space to ruminate, to think too much about the past and focus on negativity. When she wanted to do something different in the ward like dancing, it was perceived as if she were manic. She emphasized that she felt locked up with nothing to do and that she was bored. Ruwayda recommended that there should more leisure and social skills activities on offer as part of the programme in the ward.

Theme 1: "This is not a prison, it's a hospital"	
"Uhm it's basically eat, uhm sleep, medication"	x
"I must take my clothes off in front of so many women"	x
"You must keep your mouth"	x
"We need to line up"	x
"Monitoring on your section"	x
"Sitting the time out"	x
Theme 2: "We need to do more"	
"You could be doing more"	x
"Preparing a meal for my family, that's what I do"	x
"I enjoy cleaning, it's a hobby but you can't clean in hospital"	x

Table 5 - Within-case analysis for the case of Ruwayda.

Mavis

"Preparing a meal for my family is what I do"

At the time of the study Mavis was a 49-year-old divorced mother. She resided in her house with her daughter. Upon her admission to the hospital she was diagnosed with schizophrenia and HIV. She had never used substances. This was her first presentation to psychiatry. At the time of the study she was fulfilling a 4-month admission to the pre-discharge ward. Prior to her admission she had been exposed to abuse in her previous marriage. She loved her daughter. She was employed as an interpreter. She loved her job and could not wait to return to work upon discharge. Moreover, Mavis valued her job, she worked long hours at parliament and attended house sittings, sometimes until late in the evening. Mavis also felt supported in her job. Her colleagues made regular contact with her whilst she was in hospital and were welcoming her return to work. Mavis attended her follow-up appointments with the doctor and was assessed as mentally stable, adherent to her medication routine, without psychosis, well-kempt, restricted and euthymic.

One of the first things Mavis mentioned in describing her experience in the pre-discharge ward, was that she had to take care to listen to and adhere to the instructions given to her by the security staff and to watch her behaviour, else she would be transferred back to the sub-acute ward. There

was no platform for discussion; the rules were hard set and not debatable. Expressing dismay at the strict programme and the way it was executed was perceived as resisting the instructions of the staff and the understanding of the consequences of this was that MHCUs would be transferred back to the sub-acute ward.

In the pre-discharge ward, my experience there was that you just have to listen to the instructions given to you, like you just have to behave well because if you don't behave well then, they take you back to the place where you were before. [Mavis]

Mavis explained that the duties of a monitor in the pre-discharge ward varied from checking that fellow MHCUs had tidied their beds in a particular way to ensuring that the linen was picked up off the floor after bathing and ensuring that fellow MHCUs were adhering to and doing what they were expected to do, according to the rules of the pre-discharge ward.

There is a monitoring one, where, let me just think, where a patient has to check fellow patients, whether they made their beds. [Mavis]

It's that and it's also monitoring. Monitoring whether people on your section, they've made their beds well, I didn't go into that one. [Mavis]

And they would leave, go to their offices, now there are those who will still be sleeping and then they wouldn't wake up, then it will be the work of the monitor. [Mavis]

The monitor will check, to speak to those and say make your beds, so that's their work and then there will be the one who will be looking after the bathroom, whether the bathroom, like when we bath, there will be linen on the ground where we step on when we come out of the bath or when we come out the shower so that we don't slip. [Mavis]

So that other monitors will have responsibilities to take all that wet linen straight to the, I don't know whether I will say it's a place where they keep the washing. [Mavis]

Kitchen duty and monitoring share similar practices, involving MHCUs performing duties that were familiar to them. Kitchen duty as reported by Mavis, meant that she was required to assist with setting the tables in the dining room before and after mealtimes, i.e., placing the cutlery and plates on the tables and helping with the dishes in the kitchen after supper. Kitchen duties, for MHCUs that were selected, occurred for all mealtimes for the duration of one week. Mavis, another MHCU expressed that the selection of MHCUs for kitchen duties was not consistently practiced in the pre-discharge ward; at times it would occur as part of the climate meeting, but the climate meetings were not regular. Mavis understood that kitchen duties were given to MHCUs to keep them busy but also to fulfil human responsibilities in the pre-discharge ward.

Yah [yes], but I think in all this, it's just to keep us busy, just so that we realise that we're still human beings, we still have to be responsible, carry responsibilities. [Mavis]

Mavis explained that she really enjoyed the kitchen duties as it brought back her purpose and made her feel as if she were contributing towards her own life within the pre-discharge ward.

I worked in the kitchen. Yes, I worked in the kitchen and that, because I like washing dishes, I like being in the kitchen, it helped me a lot, it was bringing back that which I liked most and I worked in the kitchen yah, it was helpful. It was just decided, the sisters just looked at me and said "Mavis don't you want to help in the kitchen; it's your turn, at least help in the kitchen" I said yes, I will. [Mavis]

Mavis highlighted the fact that she loved cleaning, doing the laundry, cleaning her house, cooking and caring for her family. These things were important to her, they offered her meaning and purpose. Mavis reported that when she could not do the things, she used to do prior to her admission she felt as if parts of herself were missing.

When you're sick, when you are sick and you're in hospital, so you are somehow feeling like, I'm not complete, it's like some parts of me are missing, some of the things I used to do, I cannot do anymore. [Mavis]

Mavis felt that she's learned a great deal from the therapeutic groups in the pre-discharge ward, yet, there were more that MHCUs could have been engaged in in the pre-discharge ward. Mavis felt that not being able to engage in the activities that offered her purpose made her feel deeply uncomfortable. This happened for example especially when she saw the cleaner sweeping, it made her feel as if she could take the broom and just sweep but knew that the cleaning staff in the pre-discharge ward were employed to clean.

And the classes and talking about you are not alone, this is one thing, you are not alone, you are still a person and you are still this… they bring back that sense of worthiness, that oh okay even if I'm sick, I'm still worthy, I'm still a human being, I'm still at that level it's just that I'm weak at the moment you know. [Mavis]

Mavis indicated that through the group sessions in the pre-discharge ward she felt she had learnt about stigma and about important skills that empower people and, even though what she learnt might not have been specific to her circumstances, the skills were transferable to other areas in her life. She now felt empowered around stigma, reporting that she did not experience stigma upon return to work. Mavis expressed that the groups offered her a sense of support. She expressed that they made her feel that she was not alone in her mental illness. Group discussions made Mavis feel worthy and validated that she was still a person despite being diagnosed with a mental illness. The group sessions were important for MHCUs in the ward as they offered an opportunity to socialise; they provided support, a platform for discussions around stigma and psychoeducation as part of the ward programme. However, participants, felt that over and above the groups, they desired to be engaged in more activities that were meaningful to them.

Stigma and all those things, so when I arrive, when I left the hospital I was already prepared, oh so this kind of things called stigma and people are afraid then some will like, we're not going to go back to our friends because they were drinking with them or they were smoking with them, now with me, my friends, we're not drinking, we're not smoking, that's how they change people,

so after, when arrive at work, I just started to greet, the lady who use to come to come and see me, so I don't have the problem with the stigma and all those things. [Mavis]

Despite learning a great deal from the groups, Mavis felt that they did not prepare her for returning to work. She reported that the group sessions were instead a platform for information sharing.

I wouldn't necessarily say that it was preparing for work or what, what I've seen, those programmes, most of the programmes were information sharing and information sharing because it was, the programmes were general. They will talk about their, for instance their drugs, uh the drugs, what kind of drugs and the drugs do this and this and that and so for me it was like more of information sharing, sharing information and general, general information. [Mavis]

Mavis loved cooking and preparing meals for her family, and she had a good relationship with her daughter. Her daughter however could care for herself, but she missed cooking and ensuring that the house was clean. Mavis proudly described that preparing a meal for her family is what she does. The activity offered her a sense of accomplishment. Similarly, like cleaning, it offered her a sense of engagement in the feeling of caring and nurturing as a woman. Providing a meal for her family held meaning for her but she could not cook in the hospital as she outlined. In the hospital, the meals were prepared by the kitchen staff and served to patients in the respective wards at mealtimes.

Preparing for the family, for children, a meal, a nice meal, rice and others, yah that's what I do. [Mavis]

In the hospital I can't clean, I can't cook. [Mavis]

Home management activities and tasks were important for Mavis as well as in the lives of the other participants and spoke to her need to be doing more of them in the pre-discharge ward.

Whilst in hospital Mavis further explained that not being able to be engaged in tasks and activities that held meaning for her such as cleaning, made her felt disintegrated. Mavis explained that she felt as if a part of her was missing because she knew that when she woke in hospital that she would just eat and then after meal times, she would not be doing the dishes, nor sweeping, she would not be doing anything that held meaning for her. Not being able to be engaged in the activities that held meaning for Mavis contributed to her not feeling proud of herself. Mavis reported that she is a mother and not a child; she needed to do certain activities, like sweeping and doing the dishes. Not being able to be engaged in those activities made her feel that a part of her was missing.

And it's like I am missing part of myself, so that's the disintegration I'm talking about. It's like you missing some of yourself, part of yourself is missing because as a person is not for me, it was, I wouldn't feel proud, I was not feeling proud of myself. When I wake up and I just know, I'm just going to wake up, I won't sweep, I won't do anything, I'm just waiting to eat, I mean I'm not a small child, I'm a mother for that matter and just waiting to eat and after eating I wouldn't wash the dishes and I mean what kind of a lifestyle is this, what kind of… and just that shows you that some of, part of you is missing because if part of you is not missing. [Mavis]

Mavis reported that when she was at home and able to do activities and tasks such as cooking and cleaning, that she usually does daily, it made her feel complete. However, being hospital and thus not being able to do the sweeping and dishes she felt incomplete, because she could no longer perform those basic activities of daily living (BADLs) which held meaning for her. Mavis compared this loss of roles that came with her admission, as coming with the feeling of no longer being human or - being less than a person.

No I just mean, when you are capable of doing that which you use to do every now and then, you feel you are complete, that you are complete, you are able to do that… like now I feel like I'm complete, if I want to go somewhere I can go, if I want to do something I will do it but when you're sick, when you are sick and you're in hospital, so you are somehow feeling like, I'm not complete, it's like some parts of me are missing, some of the things I used to do, I cannot do anymore. [Mavis]

Because sometimes when you're sick, it's like you are no longer a human being especially when you're very, very sick, you feel like you are not at the level of everyone. [Mavis]

Mavis revealed that she really enjoyed cleaning and doing the laundry in her house when she was at home. She explained that she simply could not find herself in a house that was dirty. She enjoyed cleaning, especially on weekends. When she awoke, she would plan the chores for the day and then excitedly embark on her cleaning activities. Once she had completed the cleaning, she explained that she experienced a sense of joy, she walked with pride knowing that her house was clean. These positive emotions were important for her self-esteem and overall mental health.

I enjoy cleaning. It's like a hobby for me, to an extent that I don't want to find myself staying in a dirty house. When I wake up, I wake up, especially weekends, I wake up with a plan, in that plan it must be, and washing must be included. [Mavis]

Then I do the washing, I will clean the house. I, for me it's something I enjoy. And a sense of pride in doing that because after cleaning, sometimes I'm like I wish I can have a visitor coming in. When I clean, after cleaning when I come into the house, I derive joy. *That is how satisfied, I derive satisfaction, joy and pride. And I walk with that pride that at least I'm clean and my place is clean.* [Mavis]

At home Mavis usually planned and organised the various cleaning activities for the day. Her day appeared to be filled with various chores such as doing the laundry, hanging the washing, sweeping, changing the linen on the beds, changing the curtains and packing clothes. For her this was a typical day on the weekend as Mavis explained. There was so much to do at home, Mavis expressed, that sitting and doing nothing, as in the hospital, was not what she would be returning to at discharge.

I wake up in the morning, I sweep the house and I take the washing which would be there, I do the washing, cleaning the house, hang the washing, I'll be so busy throughout the day that I'm going to spend much time with the washing. I might start taking off the curtains and the

beddings and washing. I like to wash, so much of my time, I'll stand the whole day, the whole day, believe you me doing the washing, washing, packing. [Mavis]

Mavis expressed that she felt worthless without being able to engage in those occupations that held meaning to her. She explained that because she was not cooking for her family, she was not doing the laundry or cleaning whilst in hospital, she felt worthless, that those exact activities held meaning to her.

The feeling of being worthless because you can't do things you use to do at that stage, so you feel you're worthless, you feel, what the use is, I mean I can't do the washing. I used to do the washing on my own, I can't do my washing. Here I used to cook for my family; I can't cook for my family, the sense of worthlessness. [Mavis]

Mavis further explained that basic activities of daily living (BADLs) such as cleaning, laundry and cooking contributed to MHCUs feeling like a person again. At the instance of their engagement in those activities they felt good; they had a sense of pride and accomplishment. Not being afforded with meaningful occupations in the pre-discharge ward made Mavis and other MHCUs in the study feel as if they were incomplete. Mavis yearned to sweep, to clean and to be engaged in those occupations that held meaning for her.

If possible just to bring back the sense of being a person and the sense of pride, if it were possible maybe if they can just sweep, sweep their bedroom but maybe it might be difficult because for me it was a time I wish I could just take that broom and just sweep and I use to say to this lady, "can't I help you", she says "no, no, no, no, no you can't help me", but sometimes really I was wishing, I longed to just have a broom and sweep. [Mavis]

Though she was turned down the opportunity to sweep in the pre-discharge ward, Mavis had the opportunity to be on kitchen duty. She claimed that this felt tremendously good and she was so excited to help, to contribute and to be engaged. It made her feel normal again - that she was not sick. Not being engaged in those everyday occupations contributed to the stigma that existed amongst MHCUs. Meaningful engagement - in spite of how small the activities might seem -

contributed to MHCUs perspectives of themselves as contributing members of the community and society at large.

And when she was sweeping, I said to her, can't I help you no, no mam it's fine. So when I got an opportunity to work the kitchen, at least just to help somewhere, just to help to show that you are, you are normal, you are fine, you can do that which others can do because if you just getting food, it's like you are sick, you cannot do anything yours is just to be fed and I'm like yoh,[wow] while you are still sick maybe cause you get those who are really sick for them yes, it makes sense but with time you are not sick as people might think you are sick, you think I wish, I wish I can do some things, I wish I can give a patient to do some things. [Mavis]

Additionally, being able to independently dress herself and choose her clothes was important to Mavis's sense of autonomy, which she felt she didn't have in the ward, since all MHCUs wore female attire that was uniform. Mavis felt that this took away her right to exercise choice. Mavis also explained how she found meaning in making herself a cup of tea in the comfort of her home, which she was not allowed to do in the pre-discharge ward, since the kitchen staff prepared the food.

Mavis felt that the ward lacked meaningful activities, she felt bored and anxiously awaited her discharge. She recommended that reading materials in the pre-discharge ward for MHCUs would be nice to have, along with more activities.

…and then we go and sit in the, I'll call it a sitting room, and then we sit there waiting for breakfast. [Mavis]

Simply being unengaged made Mavis feel frustrated, not only was she deprived of engaging in those activities that held meaning to her, but she could not do anything else either. Mavis expressed that being in an environment that was unstimulating, rigid and punitive was detrimental to the mental health of MHCUs who were already vulnerable because of their mental illness.

You sit still quietly, or you fall asleep. [Mavis]

Then after that we can just sit, if there is nothing to attend then we just sit. [Mavis]

Somewhere, somehow, I got so frustrated because I'm not used to just eat and sit. [Mavis]

Mavis expressed that she felt a sense of loss as a result of her admission. She explained that she felt as if she had missed a lot of her life during her 4-month admission, that of which was a similar finding to Charmaine.

The past four months I felt like phew I've lost a lot. [Mavis]

She expressed that whilst in hospital she felt that they had little to do whilst they were missing out on life with their families. Missing out on life also referred to missing out on meaningful engagement in occupations that were part of her daily life prior to coming to hospital. These occupational obligations remained part of her identity despite being in a different environment.

Theme 1: "This is not a prison, it's a hospital"	
"Uhm it's basically eat, uhm sleep, medication"	X
"I must take my clothes off in front of so many women"	X
"You must keep your mouth"	X
"We need to line up"	X
"Monitoring on your section"	X
"Sitting the time out"	X
Theme 2: "We need to do more"	
"You could be doing more"	X
"Preparing a meal for my family, that's what I do"	X
"I enjoy cleaning, it's a hobby but you can't clean in hospital"	X

Table 6 – Within-case analysis for the case of Mavis.

Carmelita

"We need to do more"

At the time of the study Carmelita was a 38-year-old single woman. She was unmarried with no children. Upon her admission she was diagnosed with schizophrenia and substance use disorder. This was her second readmission. At the time of the research she was fulfilling a 4-month admission to the pre-discharge ward. Prior to her admission she had had a history of substance use. She had also been self-employed. Carmelita resided with her parents, who she spoke of as being supportive of her. As part of her job, Carmelita cleaned sand that she collected from the ocean to create therapy aids such as weighted blankets. This activity of collecting sand held meaning for her because it was one of the steps that was required of her so that she could make the therapy aid, her product. After discharge, Carmelita attended her follow-up appointments with the doctor, where she was assessed as euthymic, without psychosis, adherent to her medication routine and mentally stable.

Carmelita claimed that during her stay in the pre-discharge ward she had felt that the staff talked down to her simply because she was mentally ill. She felt that there was no consideration for her as a person and her experiences or reasons that she had fallen ill. Carmelita expressed that being diagnosed with a mental illness already made her vulnerable because she had experienced many challenges with mental health even before her admission and added to this was having to deal with discrimination in the ward. In addition, when help was sought at the psychiatric facility, she felt as if she were victimised by staff in the pre-discharge ward.

We don't have a choice; I think people need a choice. (upset tone of voice) [Carmelita]

I yah [yes], one of the kitchen staff has been on vacation now for quite some time and I don't know for how long, she's, her tone of voice, her manner, her demeanour, it's just really, really snappy and nasty and you can just see, she's a bully and you can't have a bully type personality in a mental clinic or mental hospital, you can't, you have experienced so many things before your bipolar kicks in. [Carmelita]

Just before meals, but I think the problem is that the people issuing out abusive language don't know the patients from a bar of soap, and they feel they can bark down from this throne or this

place of hierarchy or superiority and they don't even know the patients and the patient can be as sweet as anything but there's no regard for patients feelings or morale or self-esteem or nothing. We in a hospital environment, we supposed to be getting better and we supposed to be you know, we going through a change of medication or we are trying to get to tail in the four years of abuse or whatever the case may be you know and I think it's not their place to be that outspoken at all yah [yes]. [Carmelita]

Carmelita explained that communal showering impacted negatively on her self-esteem and confidence because, not only was her body exposed to others but, she were subjected to commentary from staff on the physical appearance of their bodies. The violation of their privacy coupled with the commentary of the staff in the pre-discharge ward, in affecting their self-esteem, ultimately impacted negatively on the mental health of Carmelita. Carmelita claimed that listening to the commentary by staff about the physical appearance of their bodies made her feel like a criminal who was pushed aside into an asylum and treated inhumanely.

Just they've said you know, the one security said you know, started laughing at one of the patients who were saying "Oh my word I'm so glad I don't have your body, I'm glad I'm not your husband, I wouldn't want to look at your body." They say, "Look at your body and I don't have your physical features, or I'm glad I'm not the one that has your body" so it's very rude and obnoxious and the nurses don't say anything, they just don't say nothing, nothing and just the comments. [Carmelita]

I feel pretty upset about it, I think you know, this is not the army and you start feeling like a criminal, because now you've been pushed to the side and now all this bathing style being forced on you are, you being brain washed by being told. If you don't take your medication then that's it, that's the end of your life and there's no other you know, the limit, the statements are so limitless, so limiting. [Carmelita]

Yes, in the morning. So, there some seriously abusive and manipulative, rude and nasty comments being dished out by staff to patients. [Carmelita]

According to Carmelita, the physical appearance of the bathroom facilities in the pre-discharge ward were appalling. She described them as being untidy and unhygienic. Carmelita explained the importance of the physical environment in her recovery and felt that it contributed to her mental health status. Carmelita reported that the physical environment in the pre-discharge ward was not conducive to the mental health needs of MHCUs.

The bathrooms are looking terrible, cracked toilet seats, there's missing toilet seats. I mean If you see the status it's shocking and moving to a different place, moving to a different facility, it's not for long but if you want a person to heal all round or get better, you've got to treat you know, where they sleeping, where they eating, all, everything plays a part you know. [Carmelita]

There were also different kinds of encounters with different security staff in the pre-discharge ward; some would be pleasant and others not. Carmelita explained that she felt restricted by the security staff and did not always feel free to express herself due to their presence in the ward.

Security can be sometimes very nasty in a sense of, they, some of them are very bad luck and some of them are alright, like the security that's now working now, she's lekker [nice], but the one that's going to change the shift , that's going to go home now, the 18h00 one is not so lekker [nice], she's very, she always tells me, don't keep you like a child, you just want to play, don't keep you like a child, keep you like a big women cause you grown up, If I like want to sing or dance or stuff like that . [Carmelita]

The attitude of the security staff towards the MHCUs made the MHCUs feel restricted in their self-expression, and it ultimately impacted on their occupational engagement in the pre-discharge ward. According to Carmelita and Ruwayda, the attitude of the security staff was unpredictable and not knowing how they would be treated by the new security staff when the change of shifts happened, installed a sense of fear in MHCUs.

Carmelita also voiced that a large amount of time was allocated to sleep in the pre-discharge ward. She confidently claimed that being engaged in activities was healthier for the human brain than so much sleep and sitting and doing nothing.

We get up in the morning at uhm 7:00, quarter to 7 and then bath and shower, get ready for the day uhm make sure our side cabinets are well packed and sorted out, we make our beds, so we shower we've got uhm day clothes to change into uhm and then breakfast is served. We do a morning exercise routine and we do observations, blood pressure and sugar for those don't need and then we go and then we have breakfast at 8, and then we basically sit and wait and we just, Then it's snack break, 12 is, lunch is at 12 and then, we got a lot of free time just to sit and uhm heal and nap. Uhm I don't agree that we should have so much time to nap because the medication, especially if you're on medication, you actually find if you're not… your brain is a functioning organ, it needs to be fed like a computer, all the time and the medication can have a side way or back slide effect if the brain is not fed you know. So, I don't agree with how they allow the patients to sit around and sleep all day. [Carmelita]

According to the programme in the pre-discharge ward, after lunch, around 12h30, was allocated to sleep, until 15h00 - or 14h00 on days on which a therapeutic group was scheduled. Take for example Thursday afternoon where a therapeutic group was scheduled. MHCUs would be awoken by security and nursing staff and expected to be ready, alert and to pay attention in the therapeutic group. On such afternoons where MHCUs would be awoken to attend the therapeutic group, MHCUs often slept during the group. Those that did not sleep were often not engaged, which begged the question as to whether MHCUs benefitted from the group.

I don't agree that we should have so much time to nap because the medication, especially if you're on medication, you actually find if you're not, your brain is a functioning organ, it needs to be fed like a computer, all the time and the medication can have a side way or back slide effect if the brain is not fed you know. So, I don't agree with how they allow the patients to sit around and sleep all day. [Carmelita].

Carmelita felt that it would be better to be engaged in meaningful activities than to sleep in the pre-discharge ward. She expressed that MHCUs often appeared as if they were asleep and/or sedated in the pre-discharge ward. Participant observations revealed that the physical appearance; their voices sounded sleepy and they appeared slow in their vegetative response and interactions. On the contrary some of these symptoms could well be attributed to the side effects of medication and/or even anhedonia, social withdrawal, negative affect, amongst others and were symptoms of mental illness. Despite the presentation of clinical symptoms of mental illness Carmelita expressed that there was a need for her to be engaged in more meaningful activities that were of interest and stimulating.

I think that just anything that's going to help the patients not going into the sleep mode because you find a lot of them are, it's like they getting too much sleep now, they sleeping all day and they sleeping at night and then you try and get an answer out of them and they like sleepy, they look sleepy, they sound sleepy, they thinking in a sleepy way and I just think they need to be doing more things with their hands. [Carmelita]

Carmelita once again reiterated that in the pre-discharge ward there was a sedentary routine, which was contrary to her mental health needs. She expressed that quiet time was required to heal but too much vacant time contributed to her feeling unfulfilled. For Carmelita, MHCUs were under-occupied daily in the pre-discharge ward.

It's sedentary, it's like a sedative atmosphere yes the brain, after all that psychosis, relapsing and goodness knows what, the brain needs a quiet environment to heal but not for too long because then you start running into, like you need to keep you know, keep that engine like up otherwise the engine is going to, the brain gets lazy and then it just starts to switch off. [Carmelita]

You know so it sets a tone for a very anxious kind of, it creates an anxious environment. So, I was saying is partially anxious but if there was another ward created like if there was another ward created, like one with guys and women you know then, like rehab centre or where they slept in different areas in the day and then came and work together you know. [Carmelita]

Carmelita elucidated that there should be more activities as part of the programme in the pre-discharge ward. The constant sleeping contributed to MHCUs adopting a sick role, reinforcing their inability to do anything. This in turn left participants like Mavis experiencing a loss of roles, contributing to her feeling incomplete.

So, I just think we need more physical games that we can do with our hands. A variety of games, boggle, Pictionary, scrabble it's not too high intense you know, and we should get like a pack when we get there, of notebooks so we can write, like you do in psychology, journal, we can do daily journals and you can read them back to the staff nurse you know, once a week. Painting, drawing, have a teacher come in and teach painting or just have like what you do here, you know but definitely you need an element to break the pattern of constant napping, because everyone fights over the couches and they just nap you know and even if you go for a walk in a group around the campus not far but just to get out of these four walls, you know. [Carmelita]

Carmelita expressed her concern for fellow MHCUs that had been in the facility for years in terms of being in a structure that was rigid, restrictive and lacked opportunities and meaningful activities. Carmelita expressed that her feeling was that fellow MHCUs in that position had given up hope, that they were alive but not living.

Like the patients that are in there, one over a year and one of eight months, they, it's almost like they've given up, it's like they just, they don't take care of themselves, they don't finish their meals, they are just, they fighting with the world to live you know, I think they are not having a good time as far as motivating themselves you know, so I think those are, I think you got to be so careful how long you keep people in that environment, you've got to almost give them the idea that they now in a rehab situation. It will be wiser to just have 17 and then a rehab centre where those that are going to be kept for a year don't get kept…because that ward 17, it's a pre-discharge ward and, but when you start talking to people that have been there for a year, you think this is not pre-ward, pre-discharge. What ward is this? [Carmelita]

Carmelita expressed that the therapeutic groups were simple yet important and easy to grasp and that she enjoyed the sharing of ideas, interactions with fellow patients and voicing her opinions within them. She enjoyed the social conversation that the groups had to offer her. The groups also offered her a medium of self-expression and social participation.

I think they very uh, it's really great. I think they very, it's a lot of, it's simple but it's important to learn what you are teaching us. [Carmelita]

Yah, that's been really good. I think anything to engage in activity and, activity and working with other group members, other patient's sharing ideas and sharing opinions it's been good. It's been positive. [Carmelita]

Carmelita further expressed that the OT task groups were most enjoyable because she were afforded the opportunity to be creative, using various activities, materials and equipment. The OT task group took place every Friday morning from 09h30 till 10h30 in one of the OT wards outside of the pre-discharge ward. Apart from the physiotherapy groups, OT task groups were the only other group that occurred outside of the pre-discharge ward. Most participants expressed that they had a good experience with the OT task groups - that they learnt a great deal from them but that they still felt the need to be doing more activities in the pre-discharge ward.

Okay it's very interactive when everyone gets involved and everyone has a part to play and I think that it's very good for people to write and use their skills creatively or yah, mindfully, teaching them about mindfulness or about things there is in their lives they have forgotten about so it's like a recap of who they are or what they you know what they feel, getting them to express what they feel and yah. [Carmelita]

Theme 1: "This is not a prison, it's a hospital"	
"Uhm it's basically eat, uhm sleep, medication"	x
"I must take my clothes off in front of so many women"	X
"You must keep your mouth"	X
"We need to line up"	X
"Monitoring on your section"	X
"Sitting the time out"	X
Theme 2: "We need to do more"	
"You could be doing more"	X
"Preparing a meal for my family, that's what I do"	X
"I enjoy cleaning, it's a hobby but you can't clean in hospital"	X

Table 7 - Within-case analysis for the case of Carmelita.

Sally

"I enjoy cleaning, it's a hobby, but you can't clean in hospital"

At the time of the study Sally was a 23-year-old, single female. Sally resided in her family home. She had never been married and had no children. Upon admission she was diagnosed with schizophreniform disorder. Before her admission she had been financially and physically abused by her family. At the time of the study Sally had been admitted to the hospital for four-months. This was also her first presentation to psychiatric services. Prior to her admission Sally was actively seeking a job in the field of financial auditing. She did not want to be referred for a learnership since she was qualified and was interested in pursuing a job in an auditing. Sally, however, was afraid that post discharge, people would not offer her a job when they discovered that she had had a mental illness. She had concerns as to whether to disclose her illness in interviews and whether her disclosure would limit her opportunities of becoming employed. Sally presented with residual negative symptoms of her mental illness, which affected her social participation and spontaneity in the interviews. Her interview responses were short yet effective and coherent. Sally attended her follow-up appointments where she was assessed as mentally stable.

In describing her experience in the pre-discharge ward, Sally explained that she did not agree with the manner in which MHCUs were required to bath and shower in the communal bathrooms of the pre discharge ward.

It's like a, there's a shower, bath, shower, bath. Everybody in one bathroom. [Sally]

Sally explained that they were given various duties to perform in the kitchen.

When the climate meeting maybe. Then they decide to put new kitchen staff on or whatever, new kitchen duties. [Sally]

In the pre-discharge ward, she felt that all that was available for her to do was sit and wait until there was a therapeutic group, until it was medication time, and so forth. She could not wait to leave the hospital to find a job.

No, we just sitting there. [Sally]

I was not doing anything, just sit. [Sally]

Sally understood the reason for their prolonged stay in the pre-discharge ward, sitting and doing nothing was to give staff the time to prepare the MHCUs medication for when they were discharged.

They are doing things they are preparing us to go home easy and they even give us medication and show us how to eat your medication so that you cannot stop when you are at home. You can just drink it as well. [Sally]

Sally had enjoyed cooking a variety of traditional meals before she was hospitalised. Since she had been at home post-discharge, she had been responsible for doing the cooking and cleaning of the house. Prior to her admission she had usually awoken early to prepare breakfast for the family. By contrast she did not have these opportunities to cook or clean whilst in hospital.

I enjoy cleaning, it's a hobby, but you can't clean in hospital. [Sally]

Sally explained that she enjoyed being engaged in home-management tasks and activities. She explained that she would get so immersed in them that she would forget about her problems. There was therapeutic value for Sally in doing tasks like laundry and cooking. She expressed that being engaged in these activities that were meaningful to her and her performance in them contributed positively to her self-esteem. As she said, whilst she engaged in cooking and cleaning, she felt good about herself and forgot that she was ill.

I love cooking, doing washing I feel good, just forget about everything. [Sally]

Theme 1: "This is not a prison, it's a hospital"	
"Uhm it's basically eat, uhm sleep, medication"	x
"I must take my clothes off in front of so many women"	X
"You must keep your mouth"	
"We need to line up"	X
"Monitoring on your section"	X
"Sitting the time out"	X
Theme 2: "We need to do more"	
"You could be doing more"	X
"Preparing a meal for my family, that's what I do"	X
"I enjoy cleaning, it's a hobby but you can't clean in hospital"	X

Table 8 - Within-case analysis for the case of Sally.

4.3. The collective case

It was evident across the cases that female MHCUs felt that there were not enough opportunities for meaningful occupational engagement in the pre-discharge ward. MHCUs claimed to be unstimulated and felt that they could have been engaged in more meaningful activities rather than sitting and doing nothing in the ward. MHCUs felt that they needed more activities than those that were listed as part of the programme, activities which held greater meaning to them. Carmelita, Charmaine and Ruwayda strongly asserted the need to be engaged in more activities of meaning and felt that the lack of such available opportunities was detriment to their health and well-being. Mavis subtly wished that there had been more to do in the ward, in terms of stimulating activities. Though Sally mentioned the need to have been engaged in more activities in the ward, she was not as passionate about this issue as Carmelita, Charmaine, Mavis and Ruwayda.

Mavis elaborated on the positive effect on her mental health outside of the pre-discharge ward of being engaged in tasks and activities that held meaning for her. Charmaine wished there had been more activities in the ward, claiming that the passivity and lack of activities resulted in her struggling to create her own routine and structure at home after discharge. All MHCUs voiced positive feelings and emotions when they spoke about the activities that they engaged in whilst

at home, those that held meaning to them. The female MHCUs also described the restricted environment in the pre-discharge ward as further limiting their self-expression. Ruwayda and Carmelita's voices were assertive herein, they compared the environment to that of a prison, claiming that it made them feel as if they were being punished for having a mental illness. They outlined that the manner in which that staff communicated with them made them feel as if they were less than human. The practice of constantly having to line up, the relentless monitoring, the lack of choice, the rigidity in the execution of the programme in the pre-discharge ward were practices that for them resembled those of a prison.

	Charmaine	Carmelita	Mavis	Sally	Ruwayda
Theme 1: "This is not a prison, it's a hospital"					
"Uhm it's basically eat, uhm sleep, medication"	X	X	X		X
"I must take my clothes off in front of so many women"	X	X	X		X
"You must keep your mouth"		X	X		X
"We need to line up"	X	X	X		X
"Monitoring on your section"	X	X	X	X	X
"Sitting the time out"	X	X	X	X	X
Theme 2: "We need to do more"					
"You could be doing more"	X	X	X	X	X
"Preparing a meal for my family, that's what I do"	X	X	X	X	X
"I enjoy cleaning, it's a hobby but you can't clean in hospital"	X	X	X	X	X

Table 9 - Across-case analysis.

It is important to keep in mind that there was an existing programme in the pre-discharge ward, which determined the engagement of MHCUs. MHCUs specifically reported on their perspectives of the therapeutic groups as part of the programme. They indicated that they had learnt an immense amount from the therapeutic groups but that there was enough time in a typical day to be engaged in more activities, claiming in particular a need for activities that would have greater meaning to them. Carmelita expressed that the therapeutic groups were simple yet important and easy to grasp and that she enjoyed the sharing of ideas, the interactions with fellow patients and the opportunity they offered for her to voice her opinions.

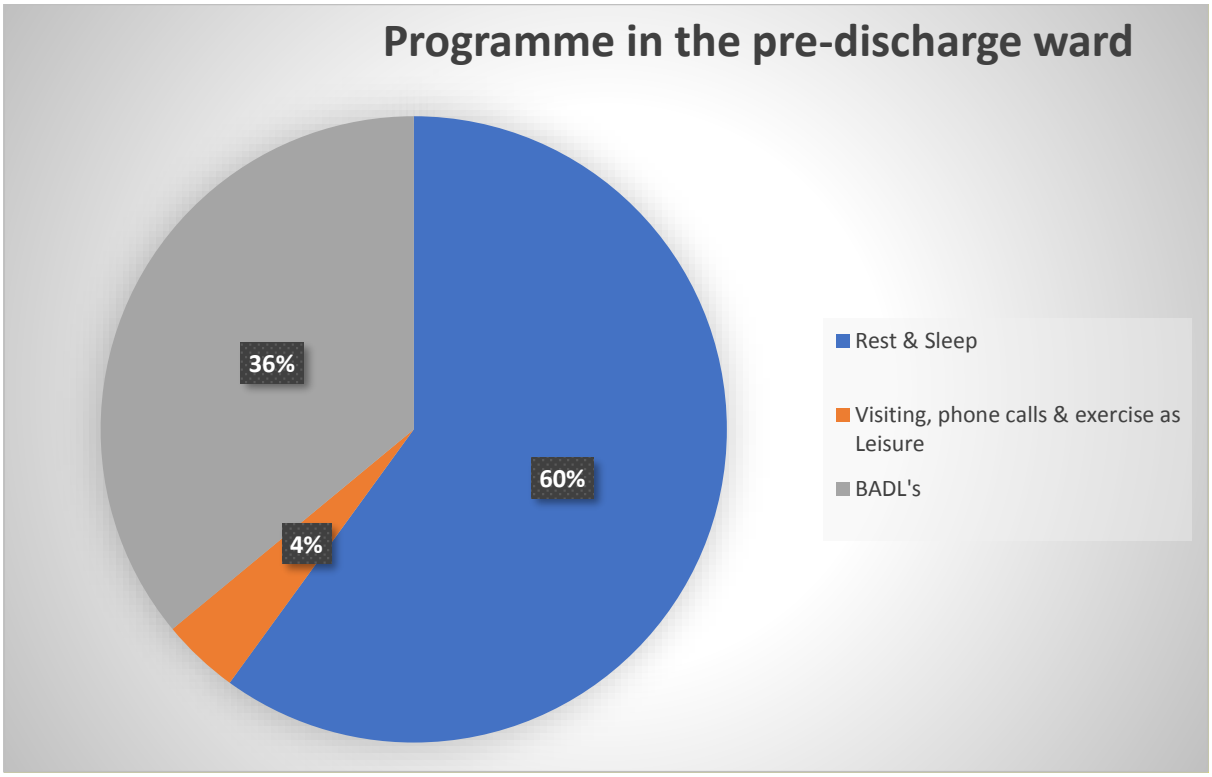


Figure 14 - A pie chart illustrating the time engaged in various activities as part of the programme in the pre-discharge ward.

The pie chart in Figure 14 represents the time allocated to the performance of each occupation in the programme of the pre-discharge ward. As outlined in chapter three, this was used for part of phase three of the multi-phased analysis. The programme in the pre-discharge ward determined the engagement of MHCUs through a typical five-day week. As we can see, 60% of time in the programme was allocated to relaxing and sleeping, indicating large amounts of unstructured time allocated for sedentary activities. Basic activities of daily living (BADLs) which

included eating, taking medication, personal hygiene and therapeutic group activities constituted 36% of the time. Four percent of the time was allocated to visiting hours, making phone calls and morning exercise, these were categorised as leisure activities. Findings from the Activities Clocks for the individual participants are represented in pie charts per case in appendix 9.

Overview of Chapter four

This chapter further presented the findings from the four data sources (the programme in the pre-discharge ward, the Activities Clocks (appendix 9), participant observations and interviews). The themes and categories were tabulated earlier in this chapter. MHCUs' voices were explicated within the cases and the similarities and differences across the cases were highlighted, within the perspectives of the occupational engagement of female MHCUs in the pre-discharge ward (Yin, 2009). The findings highlighted the environment in the pre-discharge ward. In general, the findings captured that MHCUs' needs were largely unfulfilled in the pre-discharge ward. In particular they felt a lack of opportunities for meaningful occupational engagement. Chapter five will discuss the findings.

CHAPTER FIVE

5. DISCUSSION

Introduction

This collective case study intended to understand the perspectives of female MHCUs occupational engagement in the pre-discharge ward environment at a tertiary psychiatric facility. The overall findings that emerged will be discussed below. The themes that emerged from within-case and across-cases highlighted three important aspects. Firstly, there was a perception of the pre-discharge ward environment as being rigid. Female MHCUs indicated that the way that they were treated violated their human and occupational rights. Secondly, female MHCUs indicated that in the pre-discharge ward there were few opportunities for meaningful occupational engagement. Thirdly, female MHCUs indicated that the need to be engaged in more activities of greater meaning to female MHCUs was significant. This indicated that MHCUs' needs for meaningfully engaging in activities were largely unmet and that services were not responsive to their needs. The basic needs for shelter, food, security and protection (Townsend & Wilcock, 2004) were met in the pre-discharge ward. However, many other rights were violated. The lack of opportunities for meaningful engagement was an indication of great occupational injustice towards MHCUs. The three aspects of the findings of rigidity, the need to be doing more and occupational and human right violations were part of a broader system, which reflected the occupational injustices.

Figure 15 - Key aspects of the findings as they relate to each other.

5.1. The Occupational engagement of female MHCUs in the pre-discharge ward

The experience of rigidity in the programme of the pre-discharge ward was ascribed mostly to strict rules and the lack of consultation with MHCUs. MHCUs also described what they explained as inconsistent ward practices as a stressful, a finding that resonated with Pelto-Piri et al., (2019). For participants the repetitive nature of the routines in the programme and the rigidity in its implementation resonated for MHCUs with that of a prison. MHCUs described that the practice of imposing a programme on them indicated a lack of patient-centred care in these mental health services, contrary to the Department of Healths' (DoH) vision as set out in Healthcare 2030 (WCG, 2014). Similarly, the lack of patient-centred care infringed on female MHCUs' four occupational rights which will be explained later in the discussion (Townsend & Wilcock, 2004). A clear violation of these was the lack of consultation of MHCUs in the programme of the pre-discharge ward, that would have provided valuable information about the needs of MHCUs. This also highlights a violation of occupational rights, which entail, the right to experience enrichment in an occupation, the lack of which constitutes occupational alienation. According to The Patients' Right Charter in South Africa (2007), every patient has the right to "take part in deciding on matters affecting one's health" (The Patients' Right Charter, 2007, p2.). In application to the findings of this study, this right speaks directly to patient-centred care, which in this case, since MHCUs needs were not considered in the programme, was violated.

MHCUs in the present study also reported that the ward rules were rigid and structured to the extent where they felt there were little room for improvements. A finding that was consistent with Kennedy and Fortune (2014) in Australia. In addition, the programme of the pre-discharge ward was incumbent upon MHCUs. It was created without consultation with MHCUs in terms of activities that they would have preferred to engage in. The lack of consultation of MHCUs for their contribution to the programme speaks to non-patient-centred care but also indicates how the unmet psychosocial needs of the female MHCUs disadvantaged them and demonstrated social injustices in tertiary psychiatric facilities. The lack of patient-centred care demonstrated in the findings of this study resonates with findings of other studies such Bryant et al., (2016), Hattingh & Joubert, (2019), Kennedy & Fortune, (2014), Moosa & Jeenah, (2008), Pelto-Piri et al., (2019). Porsdam, Bradley & Sahakian, (2016), Synovec, (2015) and Wright et al., (2016) echoed the findings that there were little or no room for meaningful engagement and opportunities for MHCUs at tertiary psychiatric services as found in the present study.

Structured environments create a sense of predictability, which is important for MHCUs. They also ensure balanced daily functioning. Hence, a predictable environment in the form of a structured programme was important in the pre-discharge ward. The lack of patient-centredness,

a finding in this study in the manner of the provision of a programme that did not consult the meaning or needs of MHCUs in a restrictive, occupationally-deprived environment, which violated the occupational and human rights of MHCUs, created in total an environment ill-conducive to the recovery of mental illness that may in fact contribute to their readmission (Donisi, Tedeschi, Wahlbeck, Haaramo & Amaddeo, 2016; Hamer et al., 2017; Synovec, 2015; WCG, 2014).

In addition, MHCUs described the way in which staff addressed them as being in a high-pitched voice and in a passive aggressive style. This communication style from staff to patients would be identified as authoritative. This communication style, MHCUs claim, resulted in a sense of being dehumanised. Social and occupational injustices were demonstrated in the pre-discharge ward in the manner that female MHCUs outlined having been treated with disrespect mainly be security staff. This demonstrated a violation of the requirement for respect for patients as outlined in the MHCA 17 of 2002. This finding of MHCUs feeling disrespected in the way that they were communicated with was one that was echoed by Wright et al., (2016) in Nottingham where they argued that MHCUs had negative inpatient experiences which were attributed to a communication style that contributed to a stressful environment. Thus, described communication style also indicated a hierarchy in the relationship between the MHCUs and the staff in the pre-discharge ward. It was reflective of the dominant medical model consistent with Ashby et al.,'s, (2015) narrative enquiry in Britain, of a dominant medical model in the inpatient mental health services, which demonstrated little consideration for the needs of the MHCUs. MHCUs experienced this said lack of respect from staff in the pre-discharge ward, as anxiety-provoking, contributing to what they experienced as an unsafe environment. Feeling unsafe and anxious in the pre-discharge ward was counteractive to their mental health as well as their recovery from mental illness (Pelto-Piri et al., 2019).

The Patients' Rights Charter (2007) was established to protect and promote the rights of patients in health services in South Africa. According to The Patients' Rights Charter, every patient has the right to "a healthy and safe environment that will ensure their physical and mental health or well-being" (The Patients' Rights Charter, 2007, p.1). In contrast to this, MHCUs did not feel emotionally-safe in the pre-discharge ward environment and perceived the environment to be detrimental to their mental health in some ways. This resonated with Bryant et al., (2016) in Britain who argued that the restricted ward environments, with constant monitoring and negative staff attitudes, negatively affected MHCUs. Additionally, negative staff attitudes were shown to affect the recovery regimes of MHCUs in the pre-discharge ward. MHCUs would have already generally been exposed to trauma and social injustices prior to their admission (Field et al., 2018) and then they are subject to the negative stigmatising remarks from staff, which likely affects their recovery and treatment regimes. The cycle of injustice is thus perpetuated in the pre-discharge ward, a

similar finding in South Africa by Breen et al., (2007). MHCUs in the present study compared their stay in the pre-discharge ward to that of a prison sentence in its lack of freedom and, its restrictiveness. They also compared the manner that staff communicated with them as being as though they were being punished for having a mental illness.

The rigidity and lack of patient-centred care in the pre-discharge ward environment affected the occupational engagement of female MHCUs. In the pre-discharge ward, female MHCUs had few opportunities for engagement in activities that were personally meaningful to them. A similar finding by Doroud et al., (2015). Often female MHCUs reported that they had little to do in the pre-discharge ward. The lack of opportunities of meaningful activities restricted the occupational engagement of female MHCUs, a finding consistent with Kennedy & Fortune (2014). The restrictive environment in the pre-discharge ward restricted the occupational performance of female MHCUs. This finding is contrary to evidence that recovery occurs through meaningful occupational engagement (Ikiugu et al., 2017). The lack of meaningful occupational engagement of female MHCUs in the pre-discharge ward restricted the recovery of MHCUs (Doroud et al., 2015).

5.1.1. The violation of privacy and human dignity

Communal showering amongst MHCUs in the pre-discharge ward disrespected their right to human dignity. Apart from the exposure of their naked bodies to fellow MHCUs and staff, according to them they were also subjected to commentary on the physical appearance of their bodies. This was deeply disturbing and distressing for one participant in particular in the present study. As she described it, it affected her self-image. In general, it violates MHCUs right to human dignity (Moosa & Jeenah, 2008) and subsequently contributes to MHCUs dehumanising experiences (South African Human Rights Commission, Act 40 of 2013). The human right of respect for human dignity and privacy is stipulated in the MHCA 17 of 2002. This violation was consistent with the lack of respect of personal space amongst MHCUs in other studies (Bryant et al., 2016; Kennedy & Fortune, 2014; Pelto-Piri et al., 2019).

The pre-discharge ward of the present study was constructed in such a manner that it reserved little to no privacy for MHCUs due to the fact that at the time of certification, MHCUs presented with homicidal or suicidal ideation, which meant that they were at risk to themselves and others (Moosa & Jeenah, 2008). However, this does not hold true for every MHCU in the ward. Furthermore, the fact of being transferred to the pre-discharge ward meant that the MHCUs had mainly been assessed as being much improved and as less likely to be of a risk to themselves and others. Likewise, the certification of MHCUs stemmed from the interpretation and implementation of the MHCA in South Africa. Juxtaposed to the practices in the ward that violated

the human rights of MHCUs, Moosa & Jeenah (2008) explained that the reasons for human right violations were manifold and complex. One of the reasons was the interpretation in the implementation of the MHCA 17 of 2002. When MHCUs were certified under the Act, the implications thereof were that MHCUs were susceptible to mental health interventions against their will, at the time of certification. The MHCA protects mental health practitioners in this regard. However, in the implementation of the MHCA (MHCA 17 of 2002), mental health care workers have the duty to protect the human rights of MHCUs, by treatment in the least restrictive environments possible (MHCA 17 of 2002). This practice however, according to MHCUs was not demonstrated in the findings of the present study.

5.1.2. Poor amenities

MHCUs described that amenities in the pre-discharge ward were of a poor standard. Ill-equipped physical environments resonated with resource constraints in governmental facilities (Moosa & Jeenah, 2008; WCG, 2014), which further contributed to the negative experiences of MHCUs in the pre-discharge ward. According to MHCUs the physical environment included high security measures, e.g. gated doors and locks. MHCUs described that the aesthetic appearances and general upkeep of the environment were of a poor quality and created an environment that was cold and unhygienic. Ill-equipped physical environments of tertiary psychiatric facilities contributed to MHCUs negative experiences making this type of ward environment ill-conducive to the health of MHCUs in South Africa (Moosa & Jeenah 2008). Female MHCUs reported that the bathroom facilities were unhygienic, toilets seats were broken, some toilet seats were missing. The ward was painted blue with chairs to sit on in the common living area. There was a television set but no curtains. According to MHCUs in this study the amenities in the pre-discharge ward were of a poor standard. Ulfseth et al., (2015) argued the importance of the physical environment in enabling healing in tertiary psychiatric facilities. Ulfseth et al., (2015) argued that an aesthetically-pleasing environment creates an atmosphere that makes MHCUs feel comfortable. The ward in Ulfseth et al.,'s, (2015) study was decorated by MHCUs using pot plants, pillows on soft sofas, a bookshelf with books. It had a homely feeling. Enabling environments create opportunities for meaningful occupational engagement (Ulfseth et al., 2015). Additionally, the physical environments of the pre-discharge ward did not make provision for occupation-based interventions in terms of space, logistics or safety in terms of the use of cooking facilities, equipment and facilities for basic activities of daily living (BADLs). Thus, it was a challenge to provide interventions in an occupation-based paradigm (Duad, Judd, Yau & Barnett, 2016).

5.1.3. Violation of the right to develop through participation in occupations and social inclusion

The lack of meaningful occupational engagement infringed on many occupational rights in the pre-discharge ward. Whiteford (as cited in Christiansen & Townsend, 2004) argues that occupational deprivation refers to when people experience being unable to do what is necessary and meaningful in their lives. This deprivation is due to external factors that limit people from engaging in personally-satisfying occupations (Christiansen & Townsend, 2004). MHCUs frequently experience occupational deprivation even prior to being admitted, in being are excluded from society, employment, leisure and recreational opportunities due to stigma and discrimination. The exclusion of MHCUs is usually out of their control and is instead systemic and common in communities. The lack of available meaningful opportunities for female MHCUs in the pre-discharge ward demonstrated a violation of the right to develop through participation in occupations for health and social inclusion. The lack of available meaningful opportunities also denied them equal opportunities of recovery (Frank & Muriithi, 2015) through occupational engagement (Synovec, 2015). Hamer et al., (2017) argued that occupational justice recognises that people have the need and right to be engaged in daily occupations regardless of age, gender, ability, social class or race. MHCUs in the pre-discharge ward were engaged in daily occupations but they desired more activities that were meaningful to them. The occupations that MHCUs engaged in in the pre-discharge ward were repetitive and routine, with rigid structure and no opportunities for input from MHCUs regarding the programme.

The lack of available opportunities in the pre-discharge ward for female MHCUs contributed to minimised occupational performance. Prisons had shifted from a restrictive and punitive environment to one that is rehabilitative in nature and that is conductive to the needs of inmates, through affording inmates the opportunities of occupational engagement to reach their potential (Molineux & Whiteford, 1999). The pre-discharge ward could have possibly resembled a prison due to the lack of meaningful occupational opportunities. Contrary to the lack of available opportunities for MHCUs in the pre-discharge ward, prisoners had been afforded an opportunity to exercise their occupational rights (Molineux & Whiteford, 1999). MHCUs' needs were, at the time of the study, were largely unmet through the programme in the pre-discharge ward, in particular in the lack of available opportunities for meaningful occupational engagement and in the manner in which large amounts of time were allocated to sedentary activities (Breen et al., 2007).

MHCUs yearned to be engaged in more activities, activities that held meaning to them. It is not novel that the MHCUs in the present study felt that they should be engaged in more occupations as part of the programme in the pre-discharge ward. The desire to be engaged in more activities

in the ward has also been a consistent finding in the literature amongst MHCUs in tertiary psychiatric facilities (Bryant et al.,2016; Kennedy & Fortune, 2014; Lindgren et al., 2018; Pelto-Piri et al.,2019).

5.1.4. Violation of the right to exert individual or population autonomy through choice in occupations

Occupational marginalization refers to broader social justice (Townsend & Wilcock, 2004). However, occupational marginalization speaks to the need for people to exercise micro, everyday choices and to have decision-making power to participate in occupations (Townsend & Wilcock, 2004). Occupational marginalization in this regard may not be overtly presented as discrimination. However, occupational marginalization presents in subtle practices, expectations, standardization that dictate how, when and where people should participate (Townsend & Wilcock, 2004). Occupational engagement in the pre-discharge ward was determined by staff in the ward, who determined the types of activities that MHCUs should engage in as well as the times that these activities should occur, without consultation with MHCUs. It is a need for humans to participate in the choice of their occupations for their physical, mental and spiritual health. People need to exert control in what they do (Townsend & Wilcock, 2004). The fact that they were denied choice and freedom to exert control over choice of occupations, violated the MHCUs' occupational right to exercise autonomy through choice of occupations (Townsend & Wilcock, 2004). The lack of autonomy amongst MHCUs in the pre-discharge ward around the choice of their occupational engagement was discriminatory.

The lack of autonomy to exercise choice in occupations amongst female MHCUs in the pre-discharge ward presented occupational injustice. Occupational injustices were also demonstrated in contextual factors in the pre-discharge ward such as rigidity, restrictive environments and the communication style from staff towards patients. While it is important to reserve the right of MHCUs to exert autonomy through choice in occupations. It is equally significant to appreciate that full exertion of autonomy through choice in occupations comes with great responsibility, which has implications for both MHCUs and staff within a healthcare facility. There are pertinent issues to consider with exerting full autonomy through choice of occupations. Firstly, giving every MHCU the freedom to exert autonomy through choice in occupations would lead to an issue of the ethics around the appropriateness of selected activities within a healthcare facility. Secondly, ensuring the safety of both staff and patients within a healthcare environment is a great responsibility. These issues create dynamics which are challenging to navigate when allowing MHCUs complete exertion of autonomy in choice of occupations. However, the need to exert autonomy over choice in occupations could be honoured through appropriately situating the need to exert autonomy

over choice in occupations, given the opportunity, within occupation-based practice in the pre-discharge ward.

Occupation-based practice in mental health settings are however challenging (Duad et al., 2016). Ashby et al., (2015) in a narrative enquiry in Britain, argued that the medical model dominated inpatient acute mental health and community settings. This affected knowledge and discourse in occupation-based practices amongst OTs. Similarly, Duad et al., (2016) in a Delphi study in Malaysia, identified the dominance of the medical model and curative paradigm in mental health inpatient facilities as challenges to implementing occupation-based interventions.

Occupation-based practice is defined as either using occupation in practice as an end or as using occupations as a means to achieve an end (Ashby et al., 2015). Female MHCUs detailed their needs in cooking, cleaning, caring for others, going to work, crafts and leisure. Exerting autonomy though choice in occupation-based practices such as cooking, self-care, play, and leisure activities, used as a measure to restore health, was perceived as not scientific enough in medically-dominated environments where it was insisted that a rationale for practice be implemented. The implications of dominance of the biomedical model led to OT impairment-based practice, within a curative medically-oriented approach which aims to cure diseases, and as a result neglected occupation and violated MHCUs right to exert autonomy through choice in occupations. Furthermore, Perkes et al., (2015) found that despite centralising occupation in OT practice, the existence of institutional philosophies coupled with restrictive environments contributed to the challenge of maintaining occupation-focused approaches in tertiary psychiatric facilities.

Nevertheless, despite the existence of impeding factors to occupation-based practice in mental health institutions, one cannot simply discount the benefits of occupation-based practice for MHCUs, for service providers, the community and the burden of disease that mental illness poses in South Africa. That the neglect of patient-centred care in the recovery of mental illness manifested in higher readmission rates (Doroud et al., 2015) was indicative of the ongoing struggle of community reintegration and social inclusion of MHCUs (Morris & Cox, 2017). However, the benefits of recovery through occupational engagement have shown to be plentiful for service users and service providers (De Vos & Leclair, 2019; Doroud et al., 2015; Ikiugu et al., 2017; Lin et al., 2009; Smith et al., 2014; Synovec, 2015; Ulfseth et al., 2015; Zimolag & Krupa, 2009). Recovery through occupational engagement has been shown to create opportunities for developing positive self-worth (Lin et al., 2009), improvement in occupational performance, productivity and social participation (Ikiugu et al., 2017), which in turn fosters social inclusion (Frank & Muriithi, 2015) and enables MHCUs to exert autonomy through choice in occupations.

5.1.5. Violation of the right to experience occupation as meaningful and enriching

Occupational alienation is closely linked to occupational imbalance (Wilcock, 2006). It refers to people being “isolated, loss of control and choice, frustrated, estrangement from society or self as a result of engagement in occupation that does not satisfy inner needs” (Wilcock, 2006, p.343). MHCUs were expected to sleep or sit and do nothing in the common living area, for large amounts of time, when they mentioned that they would have liked to have been doing more. In this time the MHCUs could have been engaged in more meaningful activities in the pre-discharge ward. The activities in the pre-discharge ward were not satisfying female MHCUs' needs to experience occupations as enriching. The presence of the security in the pre-discharge ward restricted MHCUs and impacted on their self-expression. Townsend & Wilcock (2004) posits that people experience occupational alienation as a result of prolonged periods of isolation, emptiness, confined self-expression and lack of sense of meaning.

Occupational alienation is also related to the rigidity of the programme in the ward. The lack of offering the choice of engagement in occupations of greater meaning was a great injustice and infringed on the occupational right to experience occupation as meaningful and enriching of MHCUs (Frank & Muriithi, 2015). Consistent with Bryant et al., (2016) and Kennedy & Fortune (2014), who similarly found that MHCUs had very few activities that they engaged in tertiary psychiatric facilities, MHCUs expressed a need to be engaged in more activities in the pre-discharge ward and recognised that lack of meaningful engagement negatively impacted on their mental health. MHCUs in this study expressed desired to be engaged in tasks and activities that were of greater meaning to them and that were synonymous with their inner needs. This a finding was similar to that of Lindgren et al., (2018) who found that tertiary psychiatric facilities lacked stimulation and needed more meaningful activities as part from their programmes.

5.1.6. Violation of the right to benefit from fair privileges for diverse participation in occupations

Occupational imbalance moreover recognizes the major occupational classes of people being un-occupied, under-occupied and over-occupied. “Underemployed people are at risk for ill health because they are less likely to experience sufficient mental, physical and social exercise that provides meaning and enrichment in their lives” (Townsend & Wilcock, 2004, p.82). MHCUs were denied opportunities for diverse participation in a variety of occupations and were limited to sleep and sedentary activities. Instead, they could have been engaging in activities that were meaningful to them. The programme in the pre-discharge ward thus contributed to occupational imbalance experienced by MHCUs. Eklund and Tjörnstrand (2019) argued, in their qualitative

study on time use in relation to value and satisfying occupations amongst MHCUs, that spending more time in non-rest occupations in the areas of self-maintenance, work, productivity and leisure was experienced as being of more concrete value, such as making something or acquiring new knowledge. Sleeping at night and being active during the day showed more symbolic value to participants and outcomes of greater contentment with their daily occupations (Eklund & Tjörnstrand, 2019). Eklund and Tjörnstrand (2019) echoed the findings of the present study that MHCUs yearned to be engaged in more activities than simply sleep in the afternoon, as allocated in the programme of the pre-discharge ward.

The lack of constructive use of free time amongst people with schizophrenia was moreover found to perpetuated occupational dysfunction, leading to subsequent readmission (Smith et al., 2014). Meaningful occupational engagement, on the other hand, offered MHCUs structure and routine, two important components to maintaining occupational balance at discharge (Lin et al., 2009). The programme in the pre-discharge ward demonstrated occupational imbalance and can be said to thus have perpetuate dysfunctional behaviour. Additionally, occupational dysfunction has been associated with unmet occupational needs which results in poor health and quality of life (Lin et al., 2009).

MHCUs in the present study were marginalized and alienated in the pre-discharge ward, an occupational injustice, that tied in with the broader social injustices that the female MHCUs endured in previously-disadvantaged communities. The lack of opportunities in the ward demonstrated injustices. Hocking (2017) affirms that social injustices such as inequitable resource distribution for all sub-groups contribute to ill health. Similarly, the lack of opportunities for female MHCUs to realise their full potential, and the lack of a safe, supportive space to rediscover and shape their identities in their recovery (Doroud et al., 2015), socially excluded them from society (Baron, Hanlon, Mall, Honikman, Breuer, Kathree, Luitel, Nakku, Lund, Medhin, Patel, Petersen, Shrivastava & Tomlinson, 2016; Hocking, 2017; Yu, 2018). Moreover, factors such as the rigidity of the programme and restrictive and inconsistent routines affected the occupational engagement of female MHCUs. “If the ward environment is associated with occupational deprivation, which would echo findings in similar settings such as prisons then it would make sense to provide more opportunities for occupational engagement within the ward itself” (Bryant et al., 2016, p. 612). This quote is fundamental as it highlights the conditions that female MHCUs endured that were detrimental to their health and well-being. An environment that was restrictive, structured, unmeaningful, unstimulating and lacked opportunities was detrimental to the health and well-being of MHCUs in the pre-discharge ward. Meaningful occupational engagement was denied for female MHCUs and thus they were denied opportunities to reach their potential.

Overview of chapter five

This chapter discussed the findings of the present study, highlighting important discussion points. Rigidity, restriction and the lack of respect of human dignity in the environment of the pre-discharge ward pointed to a lack of patient-centred care. Additionally, there seems to be consensus in the literature that tertiary psychiatric facilities amounted to unsafe, emotionally charged experiences for MHCUs. An environment that engendered such an experience would evidently be contrary to the recovery of mental illness (Kennedy & Fortune, 2014). Female MHCUs in tertiary psychiatric institutions were found to lack opportunities for meaningful occupational engagement. Female MHCUs were occupationally-deprived with regard to engaging in occupations of greater meaning. MHCUs could not exercise choice in their occupational engagement in the pre-discharge ward. The programme in the ward was unresponsive to the needs of female MHCUs, which perpetuated occupational injustice. The lack of occupation-based programmes in the tertiary psychiatric facility of the study disempowered MHCUs.

CHAPTER SIX

6. CONCLUSION

This collective case study (Yin, 2009) explored the perspectives of five female MHCUs' occupational engagement in the pre-discharge ward of a tertiary psychiatric facility in the Western Cape of South Africa. The MHCUs reported dehumanising experiences attributed to the communication style, resource constraints, the restrictive and rigid programme, their lack of privacy with regard to activities of personal hygiene and other BADLs, coupled with the lack of patient-centred care. The comparison was made by MHCUs of the environment of the psychiatric facility to that of a prison. MHCUs endured gross human and occupational rights violations (Moosa & Jeenah, 2008), which was not unique to the present study (Bryant et al., 2016; Kennedy & Fortune, 2014; Lindgren et al., 2018; Pelto-Piri et al., 2019; Wright et al., 2016). The implementation of the MHCA 17 of 2002, the dominant medical model and the challenges of occupation-based practice were found to collectively contribute to the lack of occupational engagement of MHCUs in the pre-discharge ward. Thus MHCUs, an already-vulnerable group of people (Frank & Muriithi, 2015), were further done great social and occupational injustices.

The occupational engagement of the female MHCUs in the pre-discharge ward was associated with occupational injustices in many ways. The amounts of time allocated to sedentary activities, in which time MHCUs essentially did nothing, contributed to their occupational imbalance. MHCUs' needs and desires with regard to doing more meaningful activities were unmet in the pre-discharge ward. MHCUs endured occupational deprivation and expressed desires for having more activities of greater meaning to them in the pre-discharge ward. The programme in the pre-discharge did not provide opportunities of meaningful occupational engagement that would assist in the transition into community reintegration, post-discharge. The lack of opportunities of meaningful occupational engagement in the pre-discharge ward acted to reinforce previous injustices amongst MHCUs, namely those of isolation and social exclusion. Furthermore, the lack of opportunities for meaningful occupational engagement, hindered occupational performance, and reinforced dependency which would impact on readmission rates and average lengths of stay amongst MHCUs (Duad et al., 2016; Synovec, 2015).

The benefits of using occupation as a means to an end are many (De Vos & Leclair, 2019; Doroud et al., 2015; Ikiugu et al., 2017; Lin et al., 2009; Smith et al., 2014; Synovec, 2015; Ulfseth et al., 2015; Zimolag & Krupa, 2009). The provision of meaningful occupational engagement has been shown to lessen symptomatology of mental illness (De Vos & Leclair, 2019), offer the opportunity to develop skills (Ashby et al., 2015) as well as the opportunity of social participation (Synovec,

2015) and provide structure and predictability that assists with community living and functioning (DeAngelis et al., 2019). Meaningful occupational engagement in the pre-discharge ward is likely to empower MHCUs towards realising occupational justice within society, which would be achieved through affording MHCUs equal opportunities of meaningful occupational engagement (Ashby et al., 2015).

6.1. Limitations of the study

Though twelve participants initially expressed willingness to participate in the study, only five participants met the selection criterion. Data collected from a bigger sample size would have contributed to a greater understanding of the situation. It would have offered the perspectives of a broader range of participants. The researcher had to wait until the Medical Officer (MO) was available to assess capacity to consent, considering that such an assessment was additional to their existing workload. This delayed timelines, negatively affecting the recruitment of participants. Once participants were discharged from the ward and devolved, it was difficult to schedule appointments with them for second interviews, and at follow-up appointments when the interviews were scheduled, they had additional commitments. One participant did not complete the second interview as after discharge the researcher was unable to contact her, though she attempted several times.

6.2. Implications of the study

6.2.1. Service providers & policy makers

The research findings may inform service providers, i.e. tertiary psychiatric facilities, on the perspectives of MHCUs to inform decision makers on policies and the provision of mental health care services in the system. The present study contributes to the body of literature on the design and development of mental health services in the context of South Africa and globally. The aim of this study is to improve MHCUs experience and deliver mental health services that are responsive to the needs of service users and simultaneously provide patient-centred care. A call for review of the implementation of the MHCA17 of 2002 is fundamental in the findings of this study. The MHCA17 of 2002 should be implemented within a human rights framework to address the violations of human and occupations rights that perpetuate social and occupational injustices experienced by MHCUs.

An occupation-based, patient-centred ward programme that is tailored to the needs of MHCUs, in the pre-discharge ward, would align with the wider paradigm shift toward decentralisation and is responsive to the needs of MHCUs. In addition, it will be part of the realisation of the Department of Health's (DoH) vision as improving the patient experience which was found to have better

treatment outcomes in mental health, for MHCUs, as set out in Healthcare 2030 (WCG, 2014). Meaningful occupational engagement amongst MHCUs would simultaneously create an opportunity for MHCUs to better negotiate the transition from hospital to community living, empowering MHCUs with skills required for community living post-discharge (Synovec, 2015), fostering empowerment and inclusion in broader society and thus also social justice (Ikuigu et al., 2017; Morris & Cox, 2017; Kronenberg et al., 2015).

Additionally, to support the occupation-based practice in mental health, would be compulsory to establish supportive structures such as Non-Profit Organizations and leverage the assistance of health policy to reach quotas within various communities, especially in communities that were previously disadvantaged, fostering social and occupational inclusion of MHCUs.

The findings of this research advocate for additional OT posts and extending the number of mental health practitioners in psychiatric services in the Western Cape of South Africa. The impact of the lack of human and physical resources identified in this research was shown to be detrimental to both MHCUs and service providers, which perpetuated human and occupational injustices.

6.2.2. Research

There is a great need for future research in understanding the needs of MHCUs, facilitators as well as the barriers to community reintegration. Unfortunately, despite the need for it, such research was scarce in the literature (Hattingh & Joubert, 2019). Further research pertaining to the valuable role of OT in the mental health settings is imperative for the profession to thrive and rightfully claim its occupation-based practice in mental health settings. It is important that further research on the needs of MHCUs, perhaps with a different study population of MHCUs in a South African context be carried out. It would inform service providers and policy makers about the needs of MHCUs and strengthen existing evidence of the needs of MHCUs so as to provide intervention that is patient-centred. A growing body of evidence will advocate for equal opportunities for occupational engagement of MHCUs.

6.3. Recommendations

6.3.1. Tertiary psychiatric facilities

It is recommended for tertiary psychiatric facilities to fully embrace the shift in paradigm from the dominant medical model towards an occupation-based and recovery-orientated approach, one of which places the patient at the centre of care. The OT service and profession in terms of the major role it can play in the lives of MHCUs, towards healing, reintegration to community living and social justice, is seriously undervalued. More resources should be ploughed into OT supplies.

Friendlier physical environments in pre-discharge wards should also be amongst prioritised items. More resources should similarly be invested in the MDT. In establishing an MDT support group within the FAU and the broader hospital, to address staff morale, it would increase its effectiveness in delivering mental health services. Ongoing training on the implementation of the mental health care act (MHCA 17 of 2002) should be provided. Training on mental illness and how to offer supportive environments for recovery should be ongoing in tertiary psychiatric services.

6.3.2. Occupational Therapists

There is a need for OTs to reclaim their identities and roles in mental health care settings and be confident in the traditional occupation-based practice. The collaboration with existing projects within and around the facility at which the study was based at and community will increase networks of support of MHCUs. Lastly, further research is recommended, both qualitative and quantitative, in understanding the burden of mental illness on health services, on the economy and community and in understanding the perspectives of MHCUs and what their needs are. Once an occupation-based programme is established, it is recommended that research be then conducted on the success rates of the occupation-based pre-discharge ward programme, as well as on the readmission rates of MHCUs. Publication of findings of future research is recommended to enhance the body of existing knowledge of occupational science in the South African context.

References

A

American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM-5).* (5th ed.). (2013). Washington: Library Congress.

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy, 68*(1),1-48. http://dx.doi.org/10.5014/ajot.2014.682006.

Anney, V. N., Dar, P.O.B., & Salaam, E. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies, 5*(2), 272-281.

Appelbaum, P.S. (2007). Assessment of a patients' competence to treatment. *The New England Journal of Medicine, 357*(18), 1834-1840.

Ashby, S., Gray, M., Ryan, S., & James, C. (2015). Maintaining occupation-based practice in Australian mental health practice: A critical issue. *British Journal of Occupational Therapy, 78*(7), 431-439. http://doi:10.1177/0308022614564168.

Ayres, L., Kavanaugh, K., & Knafl, K. A. (2003). Within-case and across case approaches to qualitative data analysis. *Qualitative Health Research, 13*(6),871-883.

B

Bardone, E., & Lind, M. (2016). Towards a phronetic space for responsible research (and innovation). *Life Sciences, Society and Policy, 12*(5), 1-18. http://doi:10.1186/s40504-016-0040-8.

Baron, E. C., Hanlon, C., Mall, S., Honikman, S., Breuer, E., Kathree, T., Luitel, N. P. Nakku, J., Lund, C., Medhin, G., Patel, V., Petersen, I., Shrivastava, S., & Tomlinson, M. (2016). Maternal mental health in primary care in five low-and middle-income countries: A situational analysis. *BMC Health Services Research, 16*(53), 1-6. http://doi:10.1186/512313-016-1291-2.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544-559.

Bell, J. (2010). *Doing your research project: A guide for first-time researchers in education, health and social science* (5th ed.). New York: Open press.

Bloor, M., & Wood, F. (2006). *Keywords in qualitative methods: A vocabulary of research concepts* (1st ed.). London: SAGE.

Bowen, G.A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40. http://doi10.3316/QRJ0902027.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. http://doi:10.1191/478088706qp063oa.

Breen, A., Swartz, L., Flisher, A. J., Joska, J.A., Corrigall, J., Plaatjies, L., & McDonald, D, A. (2007). Experience of mental disorder in context of basic service reforms: The impact on caregiving environments in South Africa. *International Journal of Environmental Health Research, 17*(5), 327-334. http://doi:10.1080/09603120701628388.

Brown, H. K., Wilton, A.S., Ray, J.G., Dennis, C.L., Guttmann, A., & Vigod, S.N. (2019). Chronic physical conditions and risk for perinatal mental illness: A population-based retrospective cohort study. *PLoS Medicine, 16*(8), 1-15. http://doi.org/10.1371/ journal.pmed.1002864.

Bryant, W., Cordingley, K., Sims, K., Dokal-Marandi, J., Pritchard, H., Stannard, V., & Adamako, E. (2016). Collaborative research exploring mental health service user perspectives on acute inpatient occupational therapy. *British Journal of Occupational Therapy, 79*(10), 607-613. http://doi:10.1177/0308022616650899.

Burger, M., Hoosain, M., Einspieler, C., Unger, M., & Niehaus, D. (2020). Maternal perinatal mental health and infant and toddler neurodevelopment-evidence from low and middle-income countries: A systematic review. *Journal of Affective Disorder, 268*, 158-172. http://doi.org/10.1016/j.ad.2020.03.023.

C

Cambridge dictionaries online. (2020). Retrieved from http://dictionary.cambridge.org/dictionary/english/perspective.

Charlson, F. J., Ferrari, A. J., Santomauro, D. F., Diminic, S., Stockings, E., Scott, J. G., McGrath, J. J., & Whiteford, H. A. (2018). Global epidemiology and burden of schizophrenia: Findings from the global burden of disease study 2016. *Schizophrenia Bulletin, 44*(6), 1195-1203. http://doi:10.1093/schbul/sby058.

Christiansen, C. H., & Townnsend, E. A. (2004). *Occupational deprivation: When people cannot participate: Introduction to occupation, the art and science of living,* 221-242. Upper Saddle River, New Jersey, USA: Prentice Hall.

Crepeau, E. B., Cohn, E. S., & Schell, B. A. B. (2003). *Willard & Spackman's Occupational Therapy*. Philadelphia, PA: Lippincott.

Creswell, J. W. (2014). Research design: *Qualitative, quantitative and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Cynkin, S., & Robinson, A. M. (1990). *Occupational therapy and activities health: Toward health through activities.* United States of America: Library of Congress Catalogue.

D

Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods,8*(2), 35-52.

DeAngelis, T., Mollo, K., Giordano, C., Scotten, M., &Fecondo, B. (2019). Occupational therapy programming facilitates goal attainment in a community work rehabilitation setting. *Journal of Psychosocial Rehabilitation Mental Health, 6,* 107-115. https://doi.org/10.1007/s40737-018-00133-5.

De Vos, G., & Leclair, L. (2019). Food skills group value, meaning, and use with inpatients in a mental health setting. *British Journal of Occupational Therapy,* 1-11. https://doi:10.1177/0308022618823660.

Donalek, J. G. (2004). Choosing among qualitative traditions. *Urologic Nursing, 24*(5), 409-422.

Donisi, V., Tedeschi, F., Wahlbeck, K., Haaramo, P., & Amaddeo, F. (2016). Pre-discharge factors predicting readmissions of psychiatric patients: A systematic review of the literature. *BMC Psychiatry,16*(449). https://doi:org/10.1186/s12888-016-1114-0.

Doroud, N., Fossey, E., & Fortune, T. (2015). Recovery as an occupational journey: A scoping review exploring the links between occupational engagement and recovery for people with enduring mental health issues. *Australian Occupational Therapy Journal, 62*(6), 378-392. https://doi:/10.1111/1440-1630.12238.

Duad, A. Z. C., Judd, J., Yau, M., & Barnett, F. (2016). Issues in applying occupation-based intervention in clinical practice: A delphi study. *Social and Behavioural Sciences, 222*, 272-282.

Duncan, M., Swartz, L., & Kathard, H. (2011). The burden of psychiatric disability on chronically poor households: Costs part I. *South African Journal of Occupational Therapy, 41*(3), 55-63.

Du Toit, E., Niehaus, D., Jordaan, E., Koen, L., Jones, R., & Leppanen, J. (2020). Perinatal suicidality: Risk factors in South African women with mental illness. *South African Journal of Psychiatry, 26,* a1412. https://doi.org/10.4102/sajpsychiatry.v26i0.1412

E

Eklund, M., & Tjörnstrand, C. (2019). Associations between occupational and social interaction factors and well-being among people with psychiatric disabilities living in supported housing. *Journal of Occupational Science,* 1-15. https://doi:10.1080/14427591.2019.1620121.

F

Field, S., Onah, M., Van Heyningen, T., & Honikman, S. (2018). Domestic and intimate partner violence among pregnant women in a low resource setting in South Africa: A facility-based, mixed methods study. *BMC Women's Health, 18*(119), 1-13. https://doi:10.1186/s12905-018-0612-2.

Frank, G., & Muriithi, B. A. K. (2015). Theorising social transformation in occupational science: The American civil rights movement and South African struggle against apartheid as "occupational reconstructions." *South African Journal of Occupational Therapy, 45*(1), 11-20.

Franken, H., Wicomb, R., Allen, R., & Parker, J. (2018). A profile of adult acute admissions to Lentegeur Psychiatric Hospital. *South African Journal of Psychiatry, 24*. a1282. https://doi:/10.4102/sajpsychiatry.v24i0.1282.

G

Gadamer, H. G. (2004). *Truth and Method.* New York: Bloomsbury.

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research, 8*(92), 921-922. http://doi:10.1186/1472-6963-8-92.

Group Areas Act no. 41 of 1950. (1950). Retrieved from https://blogs.loc.gov/law/files/2014/01/Group-Areas-Act-1950.pdf.

H

Hamer, H. P., Kidd, J., Clarke, S., Butler, R., & Lampshire, D. (2017). Citizens un-interrupted: Practices of inclusion by mental health service users. *Journal of Occupational Science, 24*(1), 76-87. http://doi:10.1080/14427591.2016.1253497.

Hammel, K. W. (2015). Quality of life, participation and occupational rights: A capabilities perspective. *Australian Journal of Occupational Therapy, 62*, 78-85. http://doi:10.1111/1440-1630.12183.

Hancock, D. R., & Algozzine, B. (2009). *Doing case study research: A practical guide for beginning researchers.* New York: Teachers College Press.

Hattingh, R., & Joubert, P. M. (2019). Patients' opinions about referral from a tertiary specialist psychiatric hospital to primary healthcare. *The South African journal of psychiatry, 25*, 1212. https://doi.org/10.4102/sajpsychiatry.v25i0.1212.

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counselling research designs. *Journal of Counselling & Development, 89*(3), 288-295.

Hercegovac, S., Kernot, J., & Stanley, M. (2019). How qualitative case study methodology informs occupational therapy practice: A scoping review. *Occupation, Participation and Health, 40*(1), 6-16. https://doi.org/10.1177/1539449219850123.

Hocking, C. (2017). Occupational justice as social justice: The moral claim for inclusion. *Journal of Occupational Science*, *24*(1), 29-42. http://doi:10.1080/14427591.2017.1294016.

Hultqvist, J., Eklund, M., & Leufstadius, C. (2014). Empowerment and occupational engagement among people with psychiatric disabilities. *Scandinavian Journal of Occupational Therapy,* 1-8. http://doi:10.3109/11038128.2014.934916.

I

Iacono, J., Brown, A., & Holtham, C. (2009). Research methods - A case example of participant observation. *The Electronic Journal of Business Research Methods, 7*, 39-46.

Ikiugu, M. N., Nissen, R. M., Bellar, C., Maassen, A., & Van Peursem, K. (2017). Clinical effectiveness of occupational therapy in mental health: A meta-analysis. *The American Journal of Occupational Therapy, 71*(5). https://doi.org/10.5014/ajot.2017.024588.

J

Jack, H., Wagner, R. G., Petersen, I., Thom, R., Newton, C. R., Stein, A., Kahn, K., Tollman, S., & Hofman, K. J. (2014). Closing the mental health treatment gap in South Africa: A review of costs and cost-effectiveness. *Global Health Action, 1*, 1-11. http://dx.doi.org/10.3402/gha.v7.23431.

Jacob, N., & Coetzee, D. (2018). Mental illness in the Western Cape Province, South Africa: A review of the burden of disease and healthcare interventions. *South African Medical Journal, 108*(3), 176-189. http://doi:10.7196/SAMJ.2018.v108i3.12904.

Joffe, H., & Yardley, L. (2004). Content and thematic analysis. *Research methods for Clinical and Health Psychology,* 56-68. London: Sage.

K

Kennedy, J., & Fortune, T. (2014). Women's experiences of being in an acute psychiatric unit: An occupational perspective. *British Journal of Occupational Therapy, 77*(6), 296-303. http://doi:0.4276/030802214x14018723138048.

Kennedy, J., & Davis, J. A. (2017). Clarifying the construct of occupational engagement for occupational therapy practice. *Occupation, Participation and Health, 3*(2), 98-108.

Kessler, R. C., Anguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., Üstün, T. B., & Wang, P. S. (2009). The global burden of mental disorders: An update from the WHO world mental health

surveys (WMH). *Epidemiology Psychiatry Soc, 18*(1), 23-33. https://doi.org/10.1017/s1121189x00001421.

Kidd, S.A., Virdee, G., Mihalakakos, G., McKinney, C., Feingold, L., Collins, A., Davidson, L., Weingarten, R., Maples, N., & Velligan, D. (2016). The welcome basket revisited: Testing and feasibility of a brief peer support intervention to facilitate transition from hospital to community. *Psychiatric Rehabilitation Journal, 39*(4), 335-342. http://dx.doi.org/10.1037/prj0000235.

Kielhofner, G. (2006). *Research in occupational therapy: Methods of inquiry for enhancing practice.* Philadelphia: F. A Davis Company.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45,* March, 214-222.

Kronenberg, F., Kathard, H., Rudman, D. L., & Ramugondo, E. L. (2015). Can post-apartheid South Africa be enabled to humanise and heal itself*? South African Journal of Occupational Therapy, 45(1),* 20-27. http://dx.doi.org/10.17159/2310-3833/2015/v45no1a4.

Kumar, R. (2019). *Research methodology: A step-by-step guide for beginners* (5th ed.). Thousand Oaks CA: Sage.

L

Law, M., Cooper, B., & Strong, S. (1996). The person-environment-occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*(1), 9-23. http://doi:10.1177/000841749606300103.

Lentegeur Hospital (LGH) Statistics Report. (2016).

Li, D. (2004). Trustworthiness of think-aloud protocols in the study of translation processes. *International Journal of Applied Linguistics, 14(3),* 301-313.

Lin, N., Kirsh, B., Polatajko, H.J., & Seto, M.C. (2009). The nature and meaning of occupational engagement for forensic clients living in the community. *Journal of Occupational Science, 16*(2), 110-119. http://doi:10.1080/14427591.2009.9686650.

Lindgren, B. M., Molin, J., Lundström, M., Strömbäck, M., Renberg, E. S., & Ringnér, A. (2018). Does a new spatial design in psychiatric inpatient care influence patients' and staffs' perception of their care / working environment: A study protocol of a pilot study using a single-system experimental design. *BMC Pilot and Feasibility Studies, 4(191),* 1-7. https://doi.org/10.1186/s40814-018-0383-4.

M

Maher, C., Hadfield, M., Hutchings, M., & De Eyto, A. (2018). Ensuring rigor in qualitative data analysis: A design research approach to coding combining NVivo with traditional material methods. *International Journal of Qualitative Methods, 17*, 1-13. http://doi:10.1177/1609406918786362.

Mandelli, L., Petrelli, C., & Serretti, A. (2015). The role of specific early trauma in adult depression: A meta-analysis of published literature. *European Psychiatry, 30*(6), 665-680. https://doi.org/10.1016/j.eurpsy.2015.04.007.

Martin, K., Arbour, S., & Stevens, A. (2019). Impact of a co-produced initiative for mental health programming at a Canadian psychiatric hospital. *Psychosocial Rehabilitation Mental Health, 6,* 131-140. https://doi.org/10.1007/s40737-019-00148-6.

Mastroianni, A. C., Faden, R., & Federman, D. (1994). *Women in health research: Ethical and legal issues of including women in clinical trials.* United States of America: National Academies Press.

Mathias, K., Mathias, J., Goicolea, I., & Kermode, M. (2018). Strengthening community mental health competence: A realist informed case study from Dehradun, North India. *Health Social Care Community, 26,* 179-190. http://doi:10.1111/hsc.12498.

Mayers, P., Keet, N., Winkler, G., & Flisher, A. J. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *International Journal of Social Psychiatry, 56*(1), 60-73.

Mental Health Care Act 17 of 2002. (2002). Retrieved from https://www.gov.za/sites/default/files/gcis_document/201409/a17-02.pdf

Mental Health Commission. (2005). *Mental health commission annual report*. Retrieved from https://www.mhcirl.ie/File/2017_AR_Incl_OIMS.pdf.

Mizock, L. (2019). Development of a gender-sensitive and recovery-oriented intervention for women with serious mental illness. *Psychiatric Rehabilitation Journal, 42*(1), 3-8. http://dx.doi.org/10.1037/prj0000313.

Mkize, D. L. (2007). Human rights abuses at a psychiatric hospital in KwaZulu-Natal. *South African Journal of Psychiatry, 13*(4), 137-142. http://doi:10.4102/sajpsychiatry.v13i4.35.

Moosa, M. Y., & Jeenah, F. Y. (2008). Involuntary treatment of psychiatric patients in South Africa. *African Journal of Psychiatry, 11*(2), 109-112. http://doi:10.4314/ajpsy.v11i2.30261.

Molineux, M. L., & Whiteford, G. E. (1999). Prisons: From occupational deprivation to occupational enrichment. *Journal of Occupational Science, 6*(3), 124-130. http://doi:10.1080/14427591.1999.9686457.

Morris, K., & Cox, D. L. (2017). Developing a descriptive framework for "occupational engagement". *Journal of Occupational Science, 24*(2), 152-164. http://doi:10.1080/14427591.2017.1319292.

N

Neale, B., & Hanna, E. (2012). The ethics of researching lives qualitatively through time. *Timescapes Methods Guide Series,11.* https://www.academia.edu/11659024/The_ethics_of_researching_lives_qualitatively_through_time.

O

Ong, I., Cashwell, C. S., & Downs, H. A. (2019). Trauma sensitive yoga: A collective case study of women's trauma recovery from intimate partner violence. *Counselling Outcome Research and Evaluation, 10*(1), 19-33. http://doi:10.1080/21501378.2018.1521698.

Orb, A., Eisenhauer, L., & Wynaden, D. (2000). Ethics in qualitative research. *Journal of Nursing Scholarship, 33*(1), 93-96.

P

Pelto-Piri, V., Wallsten, T., Hylén, U., Nikban, I. & Kjellin, L. (2019). Feeling safe or unsafe in psychiatric inpatient care, a hospital-based qualitative interview study with inpatients in Sweden. *International Journal of Mental Health Systems, 13*(23), 1-10. http://doi:.org/10/11/86/s13033-019-0282-y.

Petersen, I., & Lund, C. (2011). Mental health service delivery in South Africa from 2000 to 2010: One step forward, one step back. *South African Medical Journal, 101*(10), 751-757. http://www.samj.org.za/index.php/samj/article/view/4841/3584.

Perkes, D., Whiteford, G., Charlesworth, G., Weekes, G., Jones, K., Brindle, S., Hoare, L., Todd, E., & Ray, M. (2015). Occupation-focused practice in justice health and forensic mental health: Using a practice-based enquiry approach. *World Federation of Occupational Therapists, 17*(2), 101-107.

Pollard, N., & Sakellariou, D. (2012). *Politics of occupation centred-practice: Reflections of occupational engagement across cultures*. UK: John Wiley & Sons.

Porsdam, M.S., Bradley, V.J., & Sahakian, B. (2016). Human rights-based approach to mental health: A review of programs. *Health and Human Rights Journal, 18*(1), 263-276.

R

Ritchie, H., & Roser, M. (2018). *Mental health: Our world in data.* Retrieved from https://ourworldindata.org/mental-health.

Roberts, T., Wang, X., Brzosowicz, P.J., & Jong, P. (2019). Cohort ascertainment and methods of analysis impact the association between cancer and genetic predisposition: The tale of breast cancer risk and lynch syndrome genes. *Genetics in Medicine.* http://doi:10.1038/s4143601904718.

Rudnick, A. (2018). Synergism of adaptive skills and supports in psychosocial rehabilitation: A theoretical inquiry. *Journal of Psychosocial Rehabilitation Mental Health, 5*, 101-102. https://doi.org/10.1007/s40737-018-0105-5.

S

Smith, R., De Witt, P., Franzsen, D., Pillay, M., Wolfe, N. & Davies, C. (2014). Occupational performance factors perceived to influence the readmission of mental health care users diagnosed with schizophrenia. *South African Journal of Occupational Therapy, 44*(1), 51-55.

Smyth, G., Harries, P., & Dorer, G. (2011). Exploring mental health service users' experiences of social inclusion in their community occupations. *British Journal of Occupational Therapy, 74(7)*, 323-331. http://doi.4276/030802211X1309913661072.

Sorsdahl, K., Stein, D., & Lund, C. (2012). Mental health services in South Africa: Scaling up and future directions. *African Journal of Psychiatry, 15,*168-171.

South African Human Rights Commission Act no.40 of 2013. (2013).Retrieved from https://www.gov.za/documents/south-african-human-rights-commission-act.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Summers, M., & Happell, B. (2003). Patient satisfaction with psychiatric services provided by a Melbourne tertiary hospital emergency department. *Journal of Psychiatric and Mental Health Nursing, 10* (3), 351-357. https://doi.org/10.1046/j.1365-2850.2003.00600.x

Sutton, D. J., Hocking, C. S., & Smythe, L. A. (2012). A phenomenological study of occupational engagement in recovery from mental illness. *Canadian Journal of Occupational Therapy, 79*(3), 142-150. http://doi:10.2182/cjot.2012.79.3.3.

Synovec, C. E. (2015). Implementing recovery model principles as part of occupational therapy in inpatient psychiatric settings. *Occupational Therapy in Mental Health*, *31*(1), 50-61. http://doi:10.1080/0164212X.2014.1001014.

T

The Patients' Rights Charter (2007). Retrieved from *http://www.doh.gov.za/docs/legislation/patientsright/chartere.html*.

Townsend, E. A., & Wilcock, A. A. (2004). Occupational justice and client-centred practice: A dialogue in progress. *Canadian Journal of Occupational Therapy, 71*(2), 75-85. https://doi.org/10.1177/000841740407100203.

Townsend, E. A. (2012). Boundaries and bridges to adult mental health: Critical occupational and capabilities perspectives of justice. *Journal of Occupational Science, 19*(1), 8-24. http://doi:10.1080/14427591.2011.639723.

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling occupation: Advancing an occupational therapy vision for health, well-being & justice through occupation* (2nd ed.). Canadian Association of Occupational Therapists: ACE Publications.

U

Ulfseth, L. A., Josephsson, S., & Alsaker, S. (2015). Meaning-making in everyday occupation at a psychiatric centre: A narrative approach. *Journal of Occupational Science*, *22*(4), 422-433. http://doi:10.1080/14427591.2014.954662.

V

Van Ditzhuijzen, J., Ten Have, M., De Graaf, R., Van Nijnatten, H. C. J., & Vollebergh, W. A. M. (2017). Correlates of common mental disorders among Dutch women who have had an abortion: A longitudinal cohort study. *Perspectives on Sexual and Reproductive Health, 49*(2), 123-131. http://doi:10.1363/PSRH.1208.

W

Watters, A. M., Pearce, C., Backman, C. L., & Suto, M. J. (2012). Occupational engagement and meaning: The experience of ikebana practice. *Journal of Occupational Science.* http://doi:10.1080/14427591.2012.709954.

Western Cape Government (WCG). (2014). *Healthcare 2030* (pp. 1-160). Pretoria: Western Cape Government.

Wilcock, A. A. (2006). *An occupational perspective of health* (2nd ed). Thorofare, NJ: Slack. http://doi:10.1177/03080226010640080.

Wilcock, A. A (2007). Occupation and health. Are they one and the same? *Journal of Occupational Science, 14*(1), 3-8. http://doi.oorg/10.108014427591.2007.9686577.

World Health Organization (WHO). (2011). *World report on disability*. Switzerland: WHO Press. https://www.who.int/disabilities/world_report/2011/report.pdf.

World Health Organization. (2013). *Comprehensive mental health action plan 2013-2020.* Switzerland: WHO Press.*https://www.who.int/mental_health/publications/action_plan/en/*.

World Health Organization. (2018). *South African mental illness, burden of disease.* Switzerland: WHO Press.https://www.who.int/mental_health/evidence/atlas/profiles-2017/ZAF.pdf?ua=1.

Wright, N., Rowley, E., Chopra, A., Gregoriou, K., & Waring, J. (2016). From admission to discharge in mental health services: A qualitative analysis of service user involvement. *Health expectations:*

An international journal of public participation in health care and health policy, *19*(2), 367–376. https://doi.org/10.1111/hex.12361.

Y

Yatham, S., Sivathasan, S., Yoon, R., da Silva, T.L., & Ravindran, A.V. (2018). Depression, anxiety, and post-traumatic stress disorder among youth in low- and middle-income countries: A review of prevalence and treatment interventions. *Asian Journal of Psychiatry, 38,* 78-91. http://doi.org/10.1016/j.ajp.2017.10.029.

Yin, R. K. (2009). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.

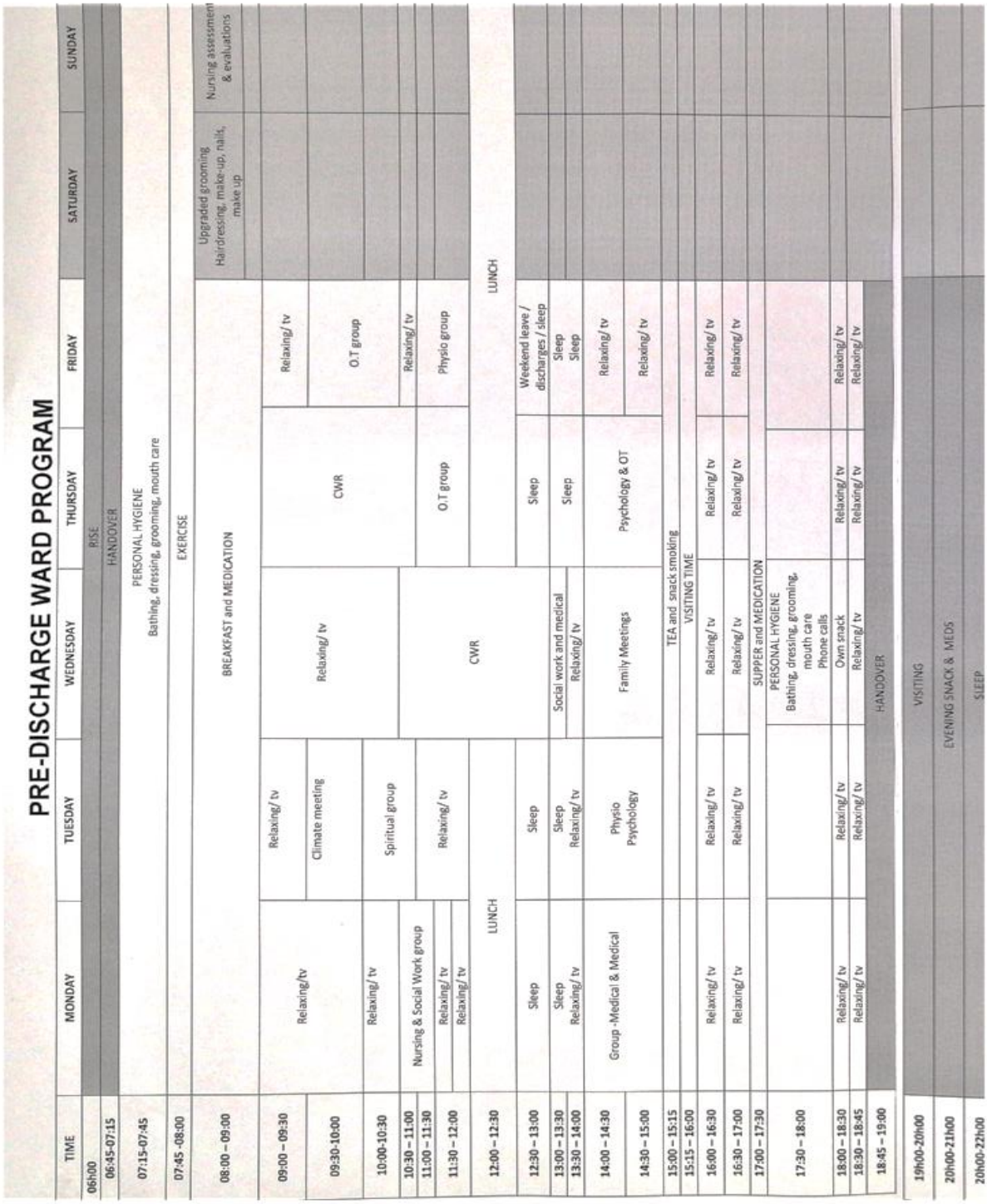
Yu, S. (2018). Uncovering the hidden impacts of inequality on mental health: A global study. *Translation Psychiatry, 9*(98), 1-10. http://doi:10.1038/S413980180148.

Z

Zach, L. (2006). Using a multiple-case studies design to investigate the information-seeking behaviour of arts administrators. *Library Trends, 55*(1), 4-21. https://doi:10.1353/lib.2006.0055.

Zimolag, U., & Krupa, T. (2009). Pet ownership as a meaningful community occupation for people with serious mental illness. *American Journal of Occupational Therapy, 63*(2), 126-137. https://doi:10.5014/ajot.63.2.126.

APPENDIX 1 – PROGRAMME IN THE PRE-DISCHARGE WARD



PRE-DISCHARGE WARD PROGRAM

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
06h00	RISE						
06:45-07:15	HANDOVER						
07:15-07:45	PERSONAL HYGIENE Bathing, dressing, grooming, mouth care						
07:45 -08:00	EXERCISE						
08:00 – 09:00	BREAKFAST and MEDICATION					Upgraded grooming Hairdressing, make-up, nails, make up	Nursing assessment & evaluations
09:00 – 09:30	Relaxing/tv	Relaxing/ tv	Relaxing/ tv	CWR	Relaxing/ tv		
09:30-10:00		Climate meeting			O.T group		
10:00-10:30	Relaxing/ tv	Spiritual group			Relaxing/ tv		
10:30 – 11:00	Nursing & Social Work group		CWR	O.T group	Physio group		
11:00 – 11:30	Relaxing/ tv	Relaxing/ tv					
11:30 – 12:00	Relaxing/ tv						
12:00 – 12:30	LUNCH			LUNCH			
12:30 – 13:00	Sleep	Sleep		Sleep	Weekend leave / discharges / sleep		
13:00 – 13:30	Sleep	Sleep	Social work and medical	Sleep	Sleep		
13:30 – 14:00	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv		Sleep		
14:00 – 14:30	Group -Medical & Medical	Physio Psychology	Family Meetings	Psychology & OT	Relaxing/ tv		
14:30 – 15:00					Relaxing/ tv		
15:00 – 15:15	TEA and snack smoking						
15:15 – 16:00	VISITING TIME						
16:00 – 16:30	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv		
16:30 – 17:00	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv		
17:00 – 17:30	SUPPER and MEDICATION						
17:30 – 18:00			PERSONAL HYGIENE Bathing, dressing, grooming, mouth care Phone calls				
18:00 – 18:30	Relaxing/ tv	Relaxing/ tv	Own snack	Relaxing/ tv	Relaxing/ tv		
18:30 – 18:45	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv	Relaxing/ tv		
18:45 – 19:00	HANDOVER						
19h00-20h00	VISITING						
20h00-21h00	EVENING SNACK & MEDS						
20h00-22h00	SLEEP						

APPENDIX 2 – DESCRIPTION OF PARTICIPANTS

Charmaine

Charmaine was a 32-year-old single mother of one child. She was Bi-lingual, fluent in English and Afrikaans. She was a victim of intimate partner violence which she endured whilst she was in the relationship with her the ex-boyfriend who is also the father of her child. She continues to struggle with stigma and discrimination in her community but is motivated to attend the groups if it were to become available in her community. Charmaine was raped in the community when she was a child. Charmaine resided in her family home with few amenities. Charmaine has a grade seven level of education and currently unemployed. Charmaine was diagnosed with Bipolar Mood disorder type 1 and had previous admissions to the facility, with a previous history of substance use. She improved on treatment. Her mental state examination (MSE) upon discharge: euthymic and without psychosis.

Sally

Sally was a 23-year-old, single female. She had no children. She was bi-lingual and fluent in IsiXhosa and English. She resided with her family and had little access to basic amenities. Sally obtained a grade twelve level of education and completed her B. Tech Degree in 2017. She has been unemployed since. This was her index presentation to psychiatry. Her psychosis settled quickly. She was diagnosed with Schizophreniform disorder and no previous history of substance use. Sally was exposed to financial and physical abuse from her family.

Ruwayda

Ruwayda is a 30-year-old married and mother of one daughter. Bi-lingual, fluent in English and Afrikaans. She resided with her husband in a Wendy house with few amenities. She continues to endure intimate partner violence from her husband yet remains in the marriage since she feels that financially she will endure hardships since she is unemployed and believes that her daughter will suffer if she decides to leave the abusive marriage. Ruwayda was previously homicidal toward her husband. Ruwayda had a grade nine level of education. She was bilingual and can communicate in both English and Afrikaans. Ruwayda was unemployed during the time in which the research was conducted. She was diagnosed with Bipolar Mood disorder and had previous admissions to the facility. Ruwayda had a previous history of substance use.

Mavis

Mavis is a 49-year-old divorced mother. She is bi-lingual and fluent in English and IsiXhosa. She is a mother to a 21-year-old daughter. She resides in her own house with access to basic amenities. Mavis is currently employed as an interpreter at parliament, at the time that the research was conducted. At the time of her admission she explained that she had great difficulty with the relationship of her ex-husband, since, he came to her house uninvited and demanded to sleep over. This becomes a pattern, one that she was not particularly impressed about. It was a stressor for her since they would argue. Her ex-husband was verbally abusive towards her and called her 'crazy'. Mavis was previously homicidal toward her ex-husband. Mavis completed grade 12 education and subsequently completed a tertiary education in languages. This was Mavis index presentation to psychiatry. Upon admission she was diagnosed with Schizophrenia and HIV. She had no previous history of substance use.

Carmelita

Carmelita is a 38-year-old single woman, with no children, currently residing with her parents and access to basic amenities. Bi-lingual and fluent in English and Afrikaans. Carmelita had a previous suicide attempt prior to her admission to the hospital. Carmelita was an entrepreneur, at the time that the research was conducted and residing with and supported by her parents. Carmelita has a grade 12 level of education and tertiary education in Arts. Celeste had previous admissions. She had no children. She was diagnosed with Schizophrenia with a history of substance use.

Average age	23
Average highest level of education	Grade 10
Tertiary education	3 out of 5
Employment status	2 out of 5 employed 3 out of 5 unemployed
Previous use of illicit substances	3 out of 5
Exposure to trauma	4 out of 5
Bipolar associated disorders	2 out of 5
Schizophrenia associated disorders	3 out of 5
Previous homicidal	2 out of 5
Previous suicide attempt	1 out of 5
Co-morbidities	1 out of 5
Access to basic amenities	2 out of 5
Had a previous admission	4 out of 5
Language proficiency	
IsiXhosa	2
English	3
Afrikaans	0

APPENDIX 3 – HREC APPROVAL

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Health Research Ethics Committee (HREC)

Approval Notice

Nevi' Application

20/04/2018

Project ID :1757

HREC Reference S17/10/220

Title: Patients' perspectives of their own occupational engagement during their admission in the pre-discharge ward of a psychiatric facility

Dear Mrs Haseena Sonday,

The Response to Modifications received on 18/04/2018 07:53 was reviewed by members of Health Research Ethics Committee 2 (HREC2) via expedited review procedures on 20/04/2018 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: This project has approval for 12 months from the date of this letter.

Please remember to use your Project ID [1757] on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct
Link and the application should be submitted to the HREC before the year has expired. Please see Forms and Instructions on our HREC website (www.sun.ac.za/healthresearchethics)for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessay). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Departement of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Westem Cape Govemment website for access to the online Health Research Approval Process, see: htt s:/lwww.we m v z I neral- ubli i n h lth-re rchapproval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms end Instrugtfpns on our HREC website https://applyethics.sun.ac.za/P(QjectView/Index/1757

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,
Francis Masiye,
HREC Coordinator,

STELLENBOSCH UNIVERSITY
Health Research Ethics Committee

2 (HREC2)2 0 APR 2018

STELLENBOSCH UNIVERSITEIT
National Health Research Ethics Council (N
Gesondheidsnavorsing
Etiekkomittee

Health Research Ethics Committ

REC) Registration Number:

0208-010 (HREC2)

Federal Wide Assurance Number: 00001372

Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number: IRB0005240 (HREC1).1RB000523S (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by theWQHW Medical Association (2013). Declaration of Helsinki:

Ethical Princi les for Medical Research Involvino Human SuWects;the South African Department of Health (2006). Guidelines for Good Practice in th nduct f lini al Trial wi h Human P i i n in South Afri nd edition ; as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes and Structures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and

Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federat Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.

APPENDIX 4 – DEPARTMENT OF HEALTH APPROVAL

Health Impact Assessment
Health Research Sub- Directorate
Health.Research@westerncape.gov.za lei: +27 21 483 0866: fax: +27 21 483 9895 5th Floor, Norton Rose House„ 8 Riebeek Street, Cape Town, 8001 www.capegateway.gov.za)

REFERENCE: WC 201804 028
ENQUIRIES:
[redacted] Dr Sabela Petros

Stellenbosch University

Faculty of Health Sciences

Tygerberg Hospital

Parow Valley

Cape Town

7535

For attention: Mrs Haseena Sonday

Re: Patient's perspectives of their own occupational engagement during their admission in the predischarge ward of a psychiatric facility.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to following people to assist you with any further enquiries in accessing the following sites:

Lentegeur Hospital	Ms Nadine Jacobs	021 370 1 105

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator

(Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the estimated completion date

which was submitted, researchers are expected to complete and submit a progress report (Annexure 8) to the provincial Research Co-ordinator

(Health.Research@westerncape.gov.za).

4. The reference number above Should be quoted in all future correspondence.
5. Your approval is valid till the 16 January 2019.

Yours sincerely

S

DR J EVANS

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

23/05/2018

DATE:

APPENDIX 5 – THE ACTIVITIES CLOCK

Extracted from Cynkin & Robinson, 1990, p.46

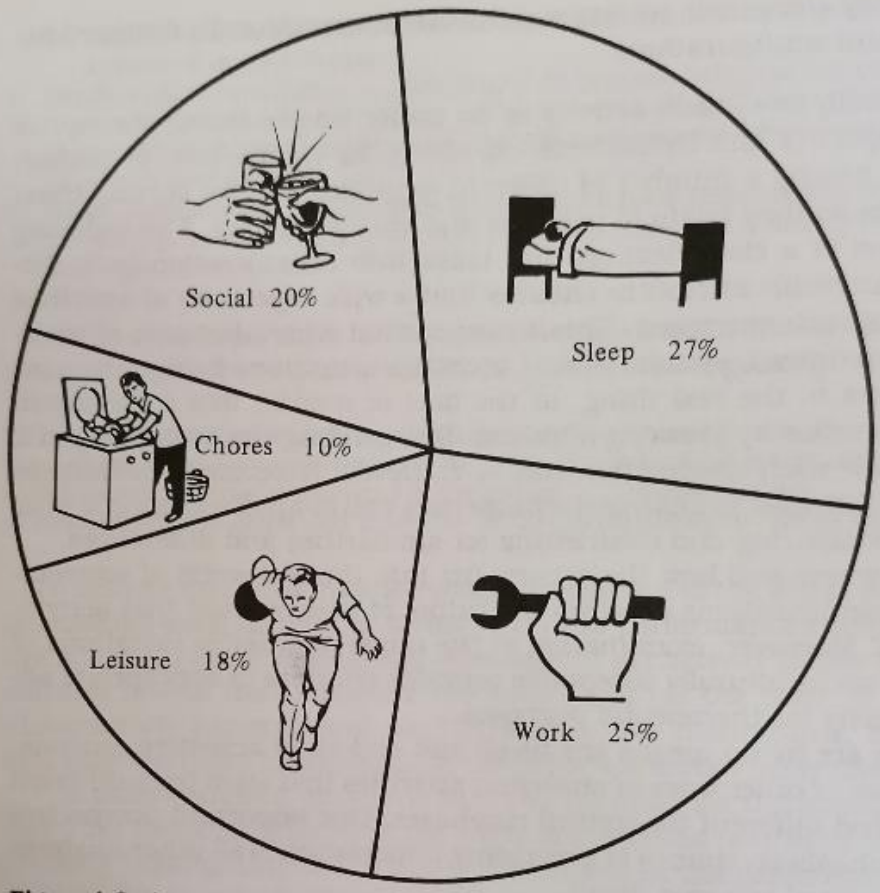


Figure 4-3. Activities clock. This clock shows the relative number of hours

APPENDIX 6 – FIRST INTERVIEW GUIDE

QUALITATIVE INTERVIEW GUIDE FIRST INTERVIEWS

TITLE OF THE RESEARCH PROJECT: FEMALE MENTAL HEALTH CARE USERS' PERSPECTIVES OF THEIR OCCUPATIONAL ENGAGEMENT AT A TERTIARY PSYCHIATRIC FACILITY

REFERENCE NUMBER: S17/10/220
RESEARCHER: HASEENA SONDAY
ADDRESS: LENTEGEUR PSYCHIATRIC HOSPITAL, MITCHELL'S PLAIN, 7785
CONTACT NUMBER: 082 865 8275

1. What are the things that you enjoy doing that makes you feel good about yourself, what are those things?
2. What makes this activities/tasks (that you have mentioned) important to you?
3. What is your experience of your illness, in the pre-discharge ward, in hospital?
4. What is your experience of your illness out of hospital?
5. What do you do for enjoyment?
6. What do you do for relaxation?
7. What makes it difficult for you to do these things that you enjoy doing, when you are ill? In the pre-discharge ward, in the hospital?
8. Tell me about your daily routine when you are at home?
9. What support is offered to you in and around your community?
10. What about being a community member?

APPENDIX 7 – SECOND INTERVIEW GUIDE

QUALITATIVE INTERVIEW GUIDE SECOND INTERVIEW

TITLE OF THE RESEARCH PROJECT: FEMALE MENTAL HEALTH CARE USERS' PERSPECTIVES OF THEIR OCCUPATIONAL ENGAGEMENT AT A TERTIARY PSYCHIATRIC FACILITY

REFERENCE NUMBER: S17/10/220
RESEARCHER: HASEENA SONDAY
ADDRESS: LENTEGEUR PSYCHIATRIC HOSPITAL, MITCHELL'S PLAIN, 7785
CONTACT NUMBER: 082 865 8275

1. Talk to me about your life roles, now that you are home?
2. Tell me about your daily routine now that you are home?
3. What is your view of the ward program in the pre-discharge ward?
4. What are you currently doing to relax and for enjoyment, now that you are home?
5. Tell me about the routine in the pre-discharge ward and its preparation for discharge?
6. Tell me about the support offered to you within and around your community, now that you are home.
7. Are you doing the things that you enjoy doing? In yes/no, please explain.
8. What can you tell me about your experience of being in the pre-discharge ward?

APPENDIX 8 – INFORMATION AND CONSENT FORMS

INFORMATION AND CONSENT FORMS - ENGLISH

TITLE OF THE RESEARCH PROJECT: FEMALE MENTAL HEALTH CARE USERS' PERSPECTIVES OF THEIR OCCUPATIONAL ENGAGEMENT AT A TERTIARY PSYCHIATRIC FACILITY

REFERENCE NUMBER: S17/10/220
RESEARCHER: HASEENA SONDAY
ADDRESS: LENTEGEUR PSYCHIATRIC HOSPITAL, MITCHELL'S PLAIN, 7785
CONTACT NUMBER: 082 865 8275

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary,** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part. **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

This study plans to fully understand the stories of people with a mental illness about the activities/ tasks/ roles and routines, that is important in your life when you out of hospital. The researcher would like to include the activities/ tasks/ roles and routines that is meaningful to you within the ward programme, whilst you are in the pre-discharge ward at Lentegeur Psychiatric Hospital, so that you may return to these activities/ tasks/ roles with ease at discharge. This study will take place within the pre-discharge ward at Lentegeur Psychiatric Hospital. This study will include people with mental illness that are within the pre-discharge ward at Lentegeur Psychiatric Hospital. You will be invited to a 45 -60-minute interviews with the researcher, with tea and/ or coffee for you to enjoy whilst you share your story. You will also receive a small gift for your participation in the study. The researcher will also be observing you whilst performing your activities / tasks/ roles and routines according to the ward program. No photographs will be used in this study.

Why have you been invited to participate?

You have been invited to participate in this study because the researcher believes that the activities of daily living/ tasks/ roles and routines are important in your life, but they have been difficult for you to do after you are discharged. The researcher would like to ensure that Occupational Therapy (O.T) intervention within the ward programme is specific to the activities/ tasks/ roles and routines that is meaningful to you when you are out of hospital, and to create a safe environment for you to do these activities/ tasks / roles and routines whilst you are in hospital.

What will your responsibilities be?

You will need to participate in a 45-60-minute, face-face interview with the researcher, in one of the official languages. You will also be observed in the ward during, before and after meal times. You will need to complete a 24-hours Activities wheel, which will be explained to you in more detail later on in the process.

Will you benefit from taking part in this research?

This study has no immediate benefits. It however will benefit future patients by providing them with an opportunity to perform meaningful activities/ tasks/ roles and routines while they are in hospital. Patient's will benefit from this research as the recommendations will be used to inform the Occupational Therapy (O.T) practice and the ward programme within the pre-discharge ward at Lentegeur Psychiatric Hospital.

Are there in risks involved in your taking part in this research?

There are no risks involved in this study.

Who will have access to your medical records?

Information received will be treated as highly private. It will be held on password protected computers. The names of participants will be protected by changing and replacing their real names with different names. If it is used in a publication or thesis, the names of the participants will remain anonymous. The information will be accessed by the researcher and the supervisor of the researcher only.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researcher. You will receive a copy of this information and consent form for your own records.

PARTICIPANT CONSENT FORM

TITLE OF THE RESEARCH PROJECT: FEMALE MENTAL HEALTH CARE USERS' PERSPECTIVES OF THEIR OCCUPATIONAL ENGAGEMENT AT A TERTIARY PSYCHIATRIC FACILITY

REFERENCE NUMBER: S17/10/220
RESEARCHER: HASEENA SONDAY
ADDRESS: LENTEGEUR PSYCHIATRIC HOSPITAL, MITCHELL'S PLAIN, 7785
CONTACT NUMBER: 082 865 8275

PARTICIPANT

By signing below, I (name & surname) ……..... agree to take part in a research study entitled**: Mental health care user's perspectives of their own occupational engagement, through the ward program, of the pre-discharge ward, of a tertiary psychiatric facility in the Western Cape, of South Africa.**

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (place) .....…….. on (date) ……...…….. 2018.

Signature of participant/ Care-giver/ Guardian) **Signature of witness**

DECLARATION BY INVESTIGATOR

I (name & surname) ……..……declare that:

- I explained the information in this document to ……
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (place) .....…..…….. on (date) ……..…….. 2018.

Signature of investigator **Signature of witness**

DECLARATION BY INTERPRETER

I (name & surname) ……..…….. declare that:

- I assisted the investigator (name & surname) ……

  to explain the information in this document to (name of participant) ……..…using the language medium of English/Afrikaans/isiXhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (place).....…..…….. on (date) ……..……..2018

Signature of interpreter **Signature of witness**

AFRIKAANS
INLIGTINGSBLAD

TITEL VAN DIE NAVORSINGSPROJEK: VROULIKE GEESTESGESONDHEIDSORG-GEBRUIKERS SE PERSPEKTIEWE VAN HUL BEROEPSAANVAARDING BY 'N TERSIÊRE PSIGIATRIESE FASILITEIT

VERWYSINGSNOMMER: S17/10/220
NAVORSER: HASEENA SONDAY
ADRES: LENTEGEUR PSIGIATRIESE HOSPITAAL, MITCHELL'S PLAIN, 7785
KONTAKNOMMER: 082 865 8275

U word uitgenooi om deel te neem aan 'n navorsingsprojek. Neem asseblief die tyd om die inligting wat hier aangebied word, te lees, wat die besonderhede van hierdie projek sal verduidelik. Vra die navorser enige vrae oor enige deel van hierdie projek wat u nie ten volle verstaan nie. Dit is baie belangrik dat u ten volle oortuig is dat u duidelik verstaan wat hierdie navorsing behels en hoe u betrokke kan raak. Jou deelname is ook heeltemal vrywillig en jy is vry om te weier om deel te neem. As jy nee sê, sal dit jou nie negatief beïnvloed op enige manier hoegenaamd nie. U kan ook op enige stadium van die studie onttrek, selfs al stem u nie in om deel te neem nie.

Gesondheidsnavorsingsetiekkomitee aan die Universiteit Stellenbosch en sal volgens die etiese riglyne en beginsels van die Internasionale Verklaring van Helsinki, Suid-Afrikaanse Riglyne vir GoeieKliniese Praktyk en die Mediese Navorsingsraad (MNR) se Etiese Riglyne vir Navorsing uitgevoer word.

Waaroor gaan hierdie navorsing?

Hierdie studie beplan om die stories van mense met 'n geestesongesteldheid ten volle te verstaan oor die aktiwiteite / take / rolle en roetines. Dit is belangrik in jou lewe wanneer jy buite die hospitaal is. Die navorser wil graag die aktiwiteite / take / rolle insluit wat vir u betekenisvol is in die wykprogram, terwyl u by die Lentegeur Psigiatriese Hospitaal in die voor ontslag wyk. Sodat u met gemak terugkeer na hierdie aktiwiteite / take / rolle by ontslag.Hierdie studie sal plaasvind in die voor ontslag wyk by Lentegeur Psigiatriese Hospitaal in wyk 17. Hierdie studie sal insluit mense met geestesongesteldheid wat binne die voor ontslag by Lentegeur Psigiatriese Hospitaal is. U sal uitgenooi word na 'n 45 - 60 minute onderhouds met die navorser, met tee en / of koffie vir jou om te geniet terwyl jy jou storie deel. U sal ook 'n klein geskenk ontvang vir u deelname aan die studie. Die navorser sal ook u waarneem terwyl u u aktiwiteite / take / rolle en roetines volgens die wykprogram uitvoer. Geen foto's sal in hierdie studie gebruik word nie.

Hoekom is jy genooi om deel te neem?

U is uitgenooi om deel te neem aan hierdie studie omdat die navorser van mening is dat die aktiwiteite van daaglikse lewe / take / rolle en roetines belangrik is in u lewe, maar dit was vir u moeilik om te doen wanneer u geestesongesteld is. Die navorser wil graag verseker dat Arbeidsterapie (OT) intervensie binne die wykprogram spesifiek is vir die aktiwiteite / take / rolle en roetines wat vir jou sinvol is as jy buite die hospitaal is en om 'n veilige omgewing te skep vir jou om te doen. Hierdie aktiwiteite / take / rolle en roetine terwyl jy in die hospitaal is.

Wat sal jou verantwoordelikhede wees?

U sal moet deelneem aan 'n 45-60-minute gesig-gesig-onderhoud met die navorser, in een van die amptelike tale. U sal ook gedurende, voor en na etes tye in die wyk waargeneem word. U sal 'n 24-uur-aktiwiteitewiel moet voltooi, wat later later aan u verduidelik sal word.

Sal jy baat vind by deelname aan hierdie navorsing?

Hierdie studie het geen onmiddellike voordele nie. Dit sal egter toekomstige pasiënte bevoordeel deur hulle die geleentheid te bied om daardie betekenisvolle aktiwiteite / take / rolle en roetines in die hospitaal te verrig. Pasiënt se voordeel sal baat vind by hierdie navorsing aangesien die aanbevelings gebruik sal word om die Arbeidsterapie (O.T) praktyk en die wykprogram binne die voor ontslag wyk by Lentegeur Psychiatric Hospital in te lig.

Wie sal toegang hê tot u mediese rekords?

Inligting wat ontvang word, word as vertroulik hanteer. Dit sal op wagwoord beskermde rekenaars gehou word. Die identiteit van deelnemers sal beskerm word deur die gebruik van pseudonieme. As dit in 'n publikasie of proefskrif gebruik word, sal die identiteit van die deelnemer anoniem bly. Die inligting word slegs deur die navorser en die studieleier van die navorser verkry.

Sal u betaal word om aan hierdie studie deel te neem en is daar enige koste daaraan verbonde?

Nee, jy sal nie betaal word om deel te neem aan die studie nie. Daar sal geen koste vir u wees as u deelneem nie.

Is daar enigiets anders wat jy moet weet of doen?

U kan die Gesondheidsnavorsingsetiekkomitee by 021-938 9207 kontak indien u enige besorgdheid of klagtes gehad het wat nie voldoende deur die navorser aangespreek is nie. U sal 'n afskrif van hierdie inligting en toestemmingsvorm vir u eie rekords ontvang.

DEELNAME TOESTEMMINGSVORM

TITEL VAN DIE NAVORSINGSPROJEK: VROULIKE GEESTESGESONDHEIDSORG-GEBRUIKERS SE PERSPEKTIEWE VAN HUL BEROEPSAANVAARDING BY 'N TERSIÊRE PSIGIATRIESE FASILITEIT

VERWYSINGSNOMMER: S17/10/220

NAVORSER: HASEENA SONDAY

ADRES: LENTEGEUR PSIGIATRIESE HOSPITAAL, MITCHELL'S PLAIN, 7785

KONTAKNOMMER: 082 865 8275

DEELNEMER

Deur hieronder te onderteken, ek (naam en van) ....
stem in om deel te neem aan 'n navorsingsstudie getiteld Pasiënt se perspektiewe van hul eie beroepsbetrokkenheid tydens hul toelating in die voor ontslag wyk van 'n psigiatriese fasiliteit.

Ek verklaar dat:

• Ek het hierdie inligting en toestemmingsvorm vir my gelees of gelees en dit is geskryf in 'n taal waarmee ek vlot en gemaklik is.
• Ek het die geleentheid gehad om vrae te vra en al my vrae is voldoende beantwoord.
• Ek verstaan dat deelname aan hierdie studie **vrywillig** is en ek nie onder druk is om deel te neem nie.
• Ek kan kies om die studie te eniger tyd te verlaat en sal op geen manier gepenaliseer of benadeel word nie.
• Ek mag gevra word om die studie te verlaat voordat dit afgehandel is, as die navorser voel dit is in my beste belang, of as ek nie die studieplan volg nie, soos ooreengekom.

Geteken by (plek) ..... ……..op (datum) ……. 2018.

……. …….

Handtekening van deelnemer / Sorggewer / Voog) Handtekening van getuie

VERKLARING DEUR ONDERSOEKER

Ek (naam en van) ..... verklaar dat:

• Ek het die inligting in hierdie dokument verduidelik aan .....
• Ek het hom / haar aangemoedig om vrae te vra en genoeg tyd gehad om hulle te beantwoord.
• Ek is tevrede dat hy / sy alle aspekte van die navorsing voldoende verstaan, soos hierbo bespreek
• Ek het / het nie 'n tolk gebruik nie. (As 'n tolk gebruik word, moet die tolk die onderstaande verklaring onderteken.

Geteken by (plek) ..... op (datum) .....……..... 2018.

Handtekening van ondersoeker Handtekening van getuie

VERKLARING DEUR INTERPRETER

Ek (naam en van) ..... verklaar dat:

• Ek het die ondersoeker (naam en van) bygestaan .....
om die inligting in hierdie dokument te verduidelik aan (naam van deelnemer)
..... met behulp van die taalmedium van Engels / Afrikaans / isiXhosa.
• Ons het hom / haar aangemoedig om vrae te vra en genoeg tyd gehad om dit te beantwoord.
• Ek het 'n feitelik korrekte weergawe van wat aan my verwant was, oorgedra.
• Ek is tevrede dat die deelnemer die inhoud van hierdie ingeligte toestemmingsdokument ten volle verstaan en al sy / haar vraag bevredigend beantwoord het.

Geteken by (plek) ..... op (datum) 2018

…….. ……..

Handtekening van tolk **Handtekening van getuie**

ISIXHOSA

IPHETSHANA LEENKCUKACHA

ISIQINISEKISO SEPROJEKI YOPHANDO: ISIFUNDO SEMPILO YEMPILO YEMPILO EBALASELEYO EBALASELAYO EFANELEKILEYO KWI-TERTIARY PSYCHIATRIC FACILITY

INOMBOLO YESALATHISI: S17/10/220
UMPHANDI: HASEENA SONDAY
IDILESI: LENTEGEUR PSYCHIATRIC HOSPITAL, MITCHELL'S PLAIN, 7785
INOMBOLO YOQHAGAMSHELWANO: 082 865 8275

Uyacelwa ukuba uthathe inxaxheba kwiprojekthi yophando. Nceda uthathe ixesha ufunda iinkcukacha ezibhalwe apha, eziza kucacisa ngeenkcukacha zale projekthi. Nceda ubuze umphandi ngayo nayiphi na indawo kule projekthi ongayiqondi ngokupheleleyo. Kubaluleke kakhulu ukuba waneliseke ngokupheleleyo ukuba ukuqonda ngokucacileyo okuqulathwe kolu phando nendlela onokubandakanyeka ngayo. Kwakhona, ukuthatha kwakho inxaxheba **ukwenza ngokuzithandela ngokupheleleyo,** kwaye uvumelekile ukuba ungala ekuthatheni inxaxheba. Ukuba uthi hayi, oku akuyi kukuchaphazela kakubi nangayiphi na indlela. Ukhululekile kwakhona ukuba ungarhoxa kolu phando nanini na, nkqu nokuba uyavuma ukuthatha inxaxheba. Olu phando luvunywe yi**Komiti yeeNdlela zokuZiphatha kuPhando lwezeMpilo kwiYuniversithi yaseStellenbosch** kwaye luza kwenziwa ngokwemigaqo esesikweni yokuziphatha nemigaqo eyamkelekileyo kwiSibhengezo seHlabathi sikaHelsinki, iMigaqo eLungileyo yoMzantsi Afrika yokuSebenza kwezoNyango kunye neMigaqo yeeNdlela zokuziPhatha kwezoPhando yeBhunga loPhando kwezoNyango (i-MRC).

Ngaba lumalunga nantoni olu phononongo lophando?

Olu phononongo lucetyelwe ukuqonda ngokupheleleyo amabali abantu abagula ngengqondo imisebenzi/iindima/ nezinto abazenza rhoqo, oku kubalulekile ebomini bakho xa uphuma esibhedlele. Umphandi angathanda ukuquka imisebenzi/iindima nezinto ozenza rhoqo kwinkqubo yewadi, ngoxa ukwiwadi yangaphambi kokukhululwa esibhedlele eLentegeur Psychiatric Hospital, ukuze ubuyele kule misebenzi/imisebenzi ngokulula xa ukhululwa. Olu phononongo luza kuqhutywa kwiwadi yangaphambi kokukhululwa eLentegeur Psychiatric Hospital Olu phononongo luya kuquka aba abagula ngengqondo abakwiwadi yangaphambi kokukhululwa eLentegeur Psychiatric Hospital. Uya kumenyelwa kudliwano ndlebe lwemizuzu engama-45-60 kunye nomphandi, wenzelwe iti okanye ikofu ukuze uyinandiphe ngoxa usibalisela ibali lakho. Kanti uya kufumana isipho esingephi ngenxa yokuthatha kwakho inxaxheba kolu phononongo. Umphandi uya kuba ekwakhel' umkhanya ngoxa usenza imisebenzi/iindima iimbopheleleko nezinto ozenza rhoqo ngokwenkqubo yewadi. Akusayi kusetyenziswa zifoto kolu phononongo

Kutheni uceliwe nje ukuba uthathe inxaxheba?

Uceliwe ukuba uthathe inxaxheba kolu phononongo ngenxa yokuba umphandi ucinga ukuba imisebenzi yemihla ngemihla / iindma/ nezinto ozenza rhoqo zibalulekile ebomini bakho, kodwa bekunzima ukuba uzenze emva kokuba uphumile esibhedlele. Umphandi angathanda ukuqinisekisa ukuba uNyango Ngoncedo (i-O.T) lophando nongenelelo kwinkqubo yewadi lungqale kwimisebenzi/iindima nezinto ozenza rhoqo eziluncedo kuwe xa ungaphandle kwesibhedlele, nokuyila imo ekhuselekileyo yokuba wenze le misebenzi/iindima nezinto oqhele ukuzenza ngoxa usesibhedlele.

Ziya kuba yintoni iimbopheleleko zakho?

Uya kuba nenxaxheba kudliwano ndlebe lwemizuzu engama-45-60, yobuso ngobuso kunye nomphandi, ngolunye lweelwimi ezisemthethweni. Kanti uya kujongwa ewadini ebudeni, ngaphambi nasemva kokutya. Kuya kufuneka kugqitywe umjikelo weMisebenzi yeeyure ezingama-24, oya kuwuchazelwa ngokweenkcukacha kamva kule nkqubo.

Ingaba uya kuzuza ngokuthabatha kwakho inxaxheba kolu phando?

Olu phononongo alunazinzuzo zikhawulezileyo. Noko ke luya kunceda izigulana zexesha elizayo lizinike ithuba lokwenza imisebenzi eyinzuzo/ iindima/ neembopheleleko ngoxa zisesibhedlele. Izigulana ziza kuzuza kolu phando njengoko uncomelo luza kusetyenziselwa uNyango Ngoncedo (O.T) lophando nongenelelo (O.T) nenkqubo yewadi ekwiwadi yangaphambili kokukhululwa esibhedlele eLentegeur Psychiatric Hospital.

Ngaba kukho imingcipheko ebandakanyekayo ekuthatheni kwakho inxaxheba kolu phando?

Akukho mingcipheko ibandakanyekayo kolu phononongo.

Ngubani oza kukwazi ukufikelela kwiinkcukacha zakho zonyango?

Inkcazelo efunyenweyo iya kuphathwa njengeyimfihlo ngokukhethekileyo. Iya kugcinwa kwiikhompyutha ezikhuselwe ngepaswedi. Amagama abathathinxaxheba aya kukhuselwa ngokutshintsha nangokufaka amanye amagama endaweni yamagama abo oqobo. Ukuba zithe zasetyenziswa kupapasho okanye kwingxelo engekaqinisekiswa yasesidlangaleleni, amagama abathathinxaxheba aya kugcinwa eyimfihlo. Inkcazelo iya kufikelelwa ngabaphandi nomphathi womphandi kuphela.

Ngaba uza kuhlawulwa ngokuthatha inxaxheba kolu phononongo yaye ngaba zikho iindleko ezibandakanyekayo?

Hayi, awuyi kuhlawulwa ngokuthatha inxaxheba kolu phononongo. Akusayi kubakho zindleko zibandakanyekayo kuwe, ukuba uthatha inxaxheba.

Ingaba ikhona enye into ekufuneka ukuba uyazi okanye uyenze?

Ungaqhagamshelana neKomiti yeeNdlela zokuZiphatha kuPhando lwezeMpilo ku-021 938 9207 ukuba kukho nantoni na ekuxhalabisayo engaqwalaselwanga ngokwaneleyo ngumsebenzi wezophando wakho. Uza kufumana ikopi yezi nkcukacha nefomu yesivumelwano oza kuzigcinela yona.

ISIXHOSA

IFOMU YEMVUME EYAZISIWEYO YOMTHATHINXAXHEBA

ISIQINISEKISO SEPROJEKI YOPHANDO: ISIFUNDO SEMPILO YEMPILO YEMPILO EBALASELEYO EBALASELAYO EFANELEKILEYO KWI-TERTIARY PSYCHIATRIC FACILITY

INOMBOLO YESALATHISI: S17/10/220
UMPHANDI: UHASEENA SONDAY
IDILESI: LENTEGEUR PSYCHIATRIC HOSPITAL, MITCHELL'S PLAIN, 7785
INOMBOLO YOQHAGAMSHELWANO: 082 865 8275

UMTHATHINXAXHEBA

Ngokutyikitya apha ngezantsi, mna (igama nefani) ……..... ndiyavuma ukuthatha inxaxheba kuphando olusihloko sithi: **limbono zomsebenzisi weziko lempilo yezenggondo ngemisebenzi yabo, ngenkqubo yewadi yangaphambi kokuphuma esibhedlele, kwiziko eliphezulu lezenggondo eNtshona Koloni, loMzantsi Afrika.**

Ndivakalisa ukuba:

- Ndiye ndayifunda okanye ndayifundelwa le nkcazelo nefomu yemvume yaye ibhalwe ngolwimi endiluthetha kakuhle nendiluva kakuhle.
- Ndiye ndaba nethuba lokubuza imibuzo yaye yonke imibuzo yam iphendulwe kakuhle.
- Ndiyaqonda ukuba ukuthatha kwam inxaxheba kolu phando ndikwenza **ngokuzithandela** kwaye khange ndinyanzelwe ukuba ndithathe inxaxheba.
- Ndingakhetha ukulushiya uphononongo nanini na yaye andisayi kudliwa mali okanye ndicalulwe nangayiphi na indlela.
- Ndisengacelwa ukuba ndilushiye uphando phambi kokuba lugqitywe, ukuba umsebenzi wophando ukubona kuyinzuzo kum, okanye ukuba andisilandeli isicwangciso somsebenzi wophononongo ekuvunyelwene ngaso.

Sityikityelwe (indawo) e.....…..…….. ngomhla (umhla) ……...…….. 2018.

Utyikityo lomthathinxaxheba/lomnakekeli/lomgcini **Utyikityo lwengqina**

ISIBHENGEZO SOMPHANDI

Mna (igama nefani)……..……ndivakalisa ukuba:

- Ndimcacisele u……ngeenkcukacha ezikolu xwebhu.
- Ndiye ndamkhuthaza ukuba abuze imibuzo, ndaza ndathatha ixesha elaneleyo ukuyiphendula.
- Ndanelisekile ukuba uqonda kakuhle zonke iinkalo zolu phando, njengoko kuchazwe ngasentla
- Bendinetoliki/bendingenatoliki. (*Ukuba kusetyenziswe itoliki, loo toliki mayityikitye esi sibhengezo singezantsi).*

Sityikityelwe (indawo) e.....…….. ngomhla (umhla) ……...…….. 2018.

Umtyikityo womphandi **Umtyikityo wengqina**

ISIBHENGEZO SETOLIKI

Mna (igama nefani)……..…….. ndivakalisa ukuba:

- Ndimncedisile umphandi (igama nefani)……

  ekucaciseni iinkcukacha ezikolu xwebhu *(*igama lalowo uthatha inxaxheba) ku……..…….. ndisebenzisa ulwimi lwesiNgesi/isiAfrikaans/isiXhosa.
- Siye samkhuthaza ukuba abuze imibuzo, ndaza ndathatha ixesha elaneleyo ukuyiphendula.
- Ndiye ndamnika inguqulelo echanekileyo enyanisekileyo yoko bekuthethwe kum.
- Ndanelisekile kukuba umthathinxaxheba ukuqonda ngokupheleleyo okuqulathwe lolu xwebhu lwemvume esekelwe kulwazi kwaye nemibuzo yakhe yonke iphendulwe ngokwanelisayo.

Sityikityelwe (*indawo*) e.....…….. ngomhla (*umhla*) ……...…….. 2018.

Utyikityo lwetoliki **Utyikityo lwengqina**

APPENDIX 9 – FINDINGS OF THE ACTIVITIES CLOCK PER CASE

The pie charts to follow were created from the findings of the Activities Clock for every participant. The charts detailed participants engagement in various tasks and activities in the various areas of occupations. It also provided an account of the desire to be engaged in meaningful occupational engagement.

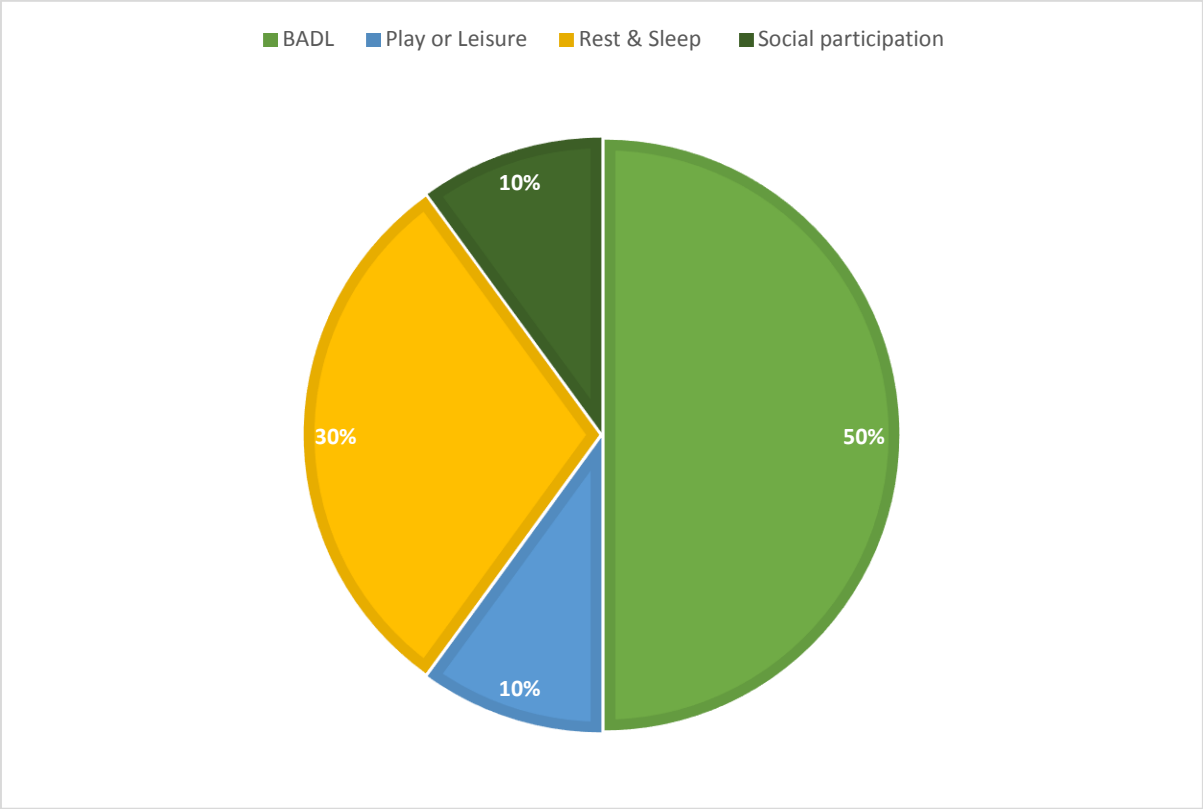


Figure 1 – Content analysis findings of the case of Charmaine Activities Clock.

BADL's included oral care, showering, grooming, and toilet hygiene, socializing, adhering to her medication routine, feeding and eating, cleaning, sweeping, mopping, laundry and tidying beds and meal preparation, which is accounted for 50% of time, spent within a typical day out of hospital. Leisure activities included walking to the shop, listening to music accounted for 10%. Spending time socializing with her niece, child and sisters accounted for 10% of time spent within a typical day out of hospital. Rest and sleep accounted for 30% of time spent within a typical day out of hospital.

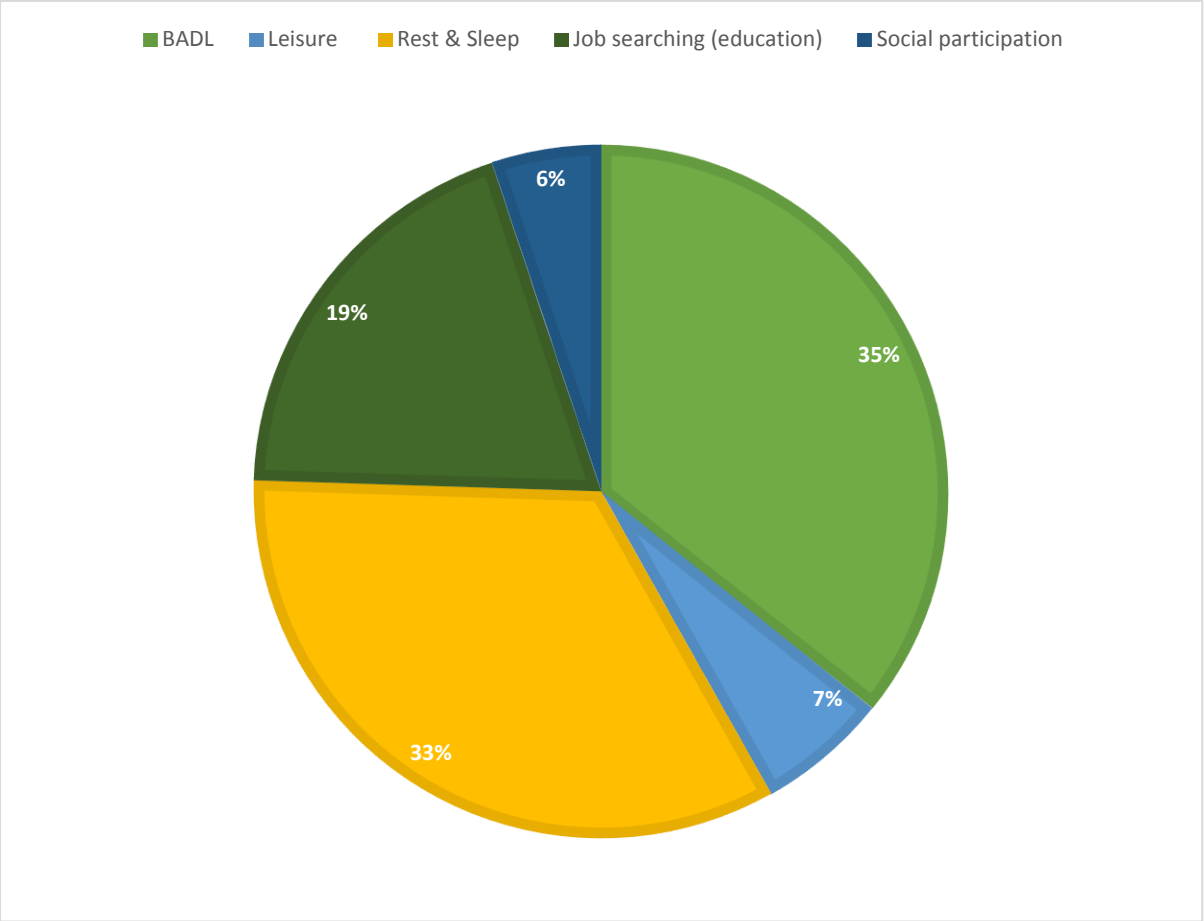


Figure 2 – Content analysis findings of the case of Sally Activities Clock.

BADL's included bathing, oral care, toilet hygiene, feeding and eating, socializing, adhering to her medication routine, grooming and dressing, cleaning – tidying of beds, sweeping, mopping, dusting, laundry, meal preparation and clean-up, which accounted for 35% of time spent within a typical day out of hospital. Engaging in job acquisition tasks such as physically looking through newspapers, searching online for available jobs accounted for 19% of time. Leisure activities included watching television 6% programs and social participation was spending time with family, which accounted for 7% of time spent within a typical day out of hospital. Rest and sleep accounted 33% of time spent within a typical day out of hospital.

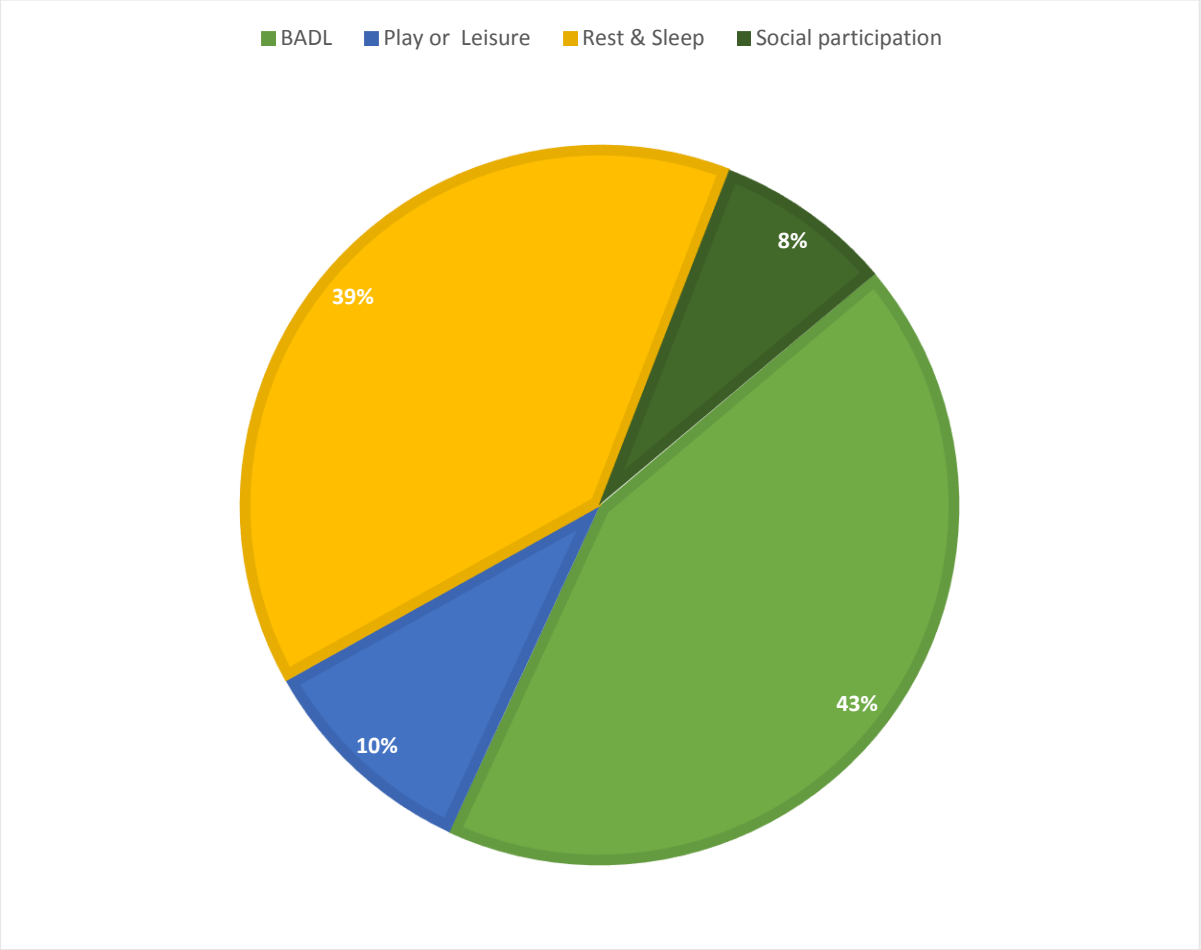


Figure 3 – Content analysis findings of the case of Ruwayda Activities Clock.

BADL's included showering, oral care, toilet hygiene, dressing, feeding and eating, adhering to her medication routine sweeping, mopping, tidying beds, laundry, meal preparation, clean-up, and caring for her daughter accounted for 43%. Leisure activities included watching television and simply relaxing on her bed before sleeping and walking to collect her daughter from school and taking her to religious centre, accounted for 10% of time. Social participation included spending time her daughter, which accounted for 8%. Rest and sleep were 39% of time spent within a typical day out of hospital.

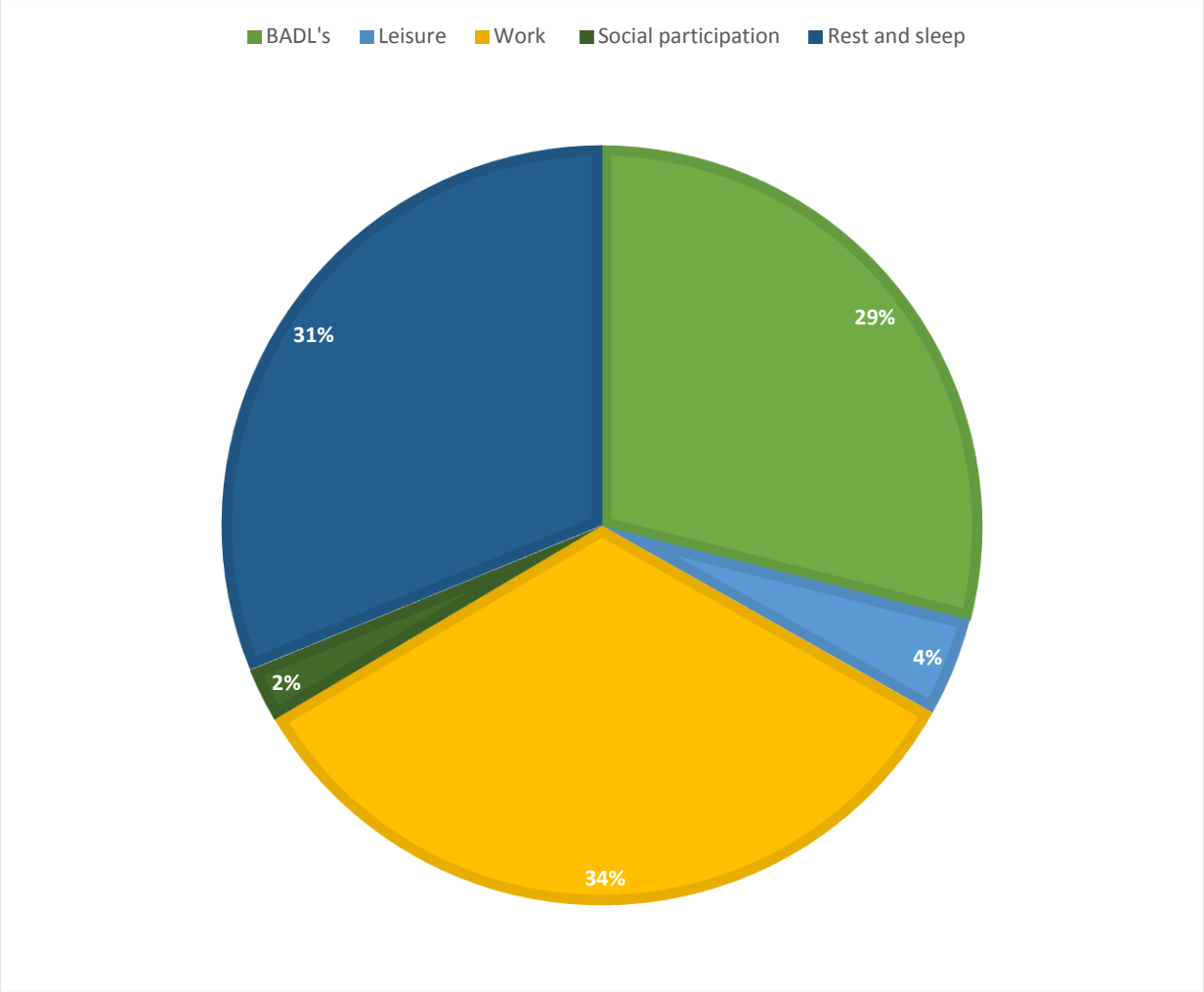


Figure 4 – Content analysis findings of the case of Mavis Activities Clock.

BADL's included tasks and activities of grooming, oral hygiene, showering, toilet hygiene, dressing, feeding and eating, taking medication, cleaning, laundry, meal preparation clean-up and IADL of driving to work, which is accounted for 29% of her time within a typical day out of hospital. Work included job performance tasks since she was employed as an interpreter, which is accounted for 34% of time within engaged in the occupation of work, in a typical day out of hospital. Leisure included reading and watching television, which is accounted for 4% of engagement, in a typical day out of hospital. Rest and sleep accounted for 31% of time. Social participation included socializing with her daughter and colleagues, accounted for 2% of time.

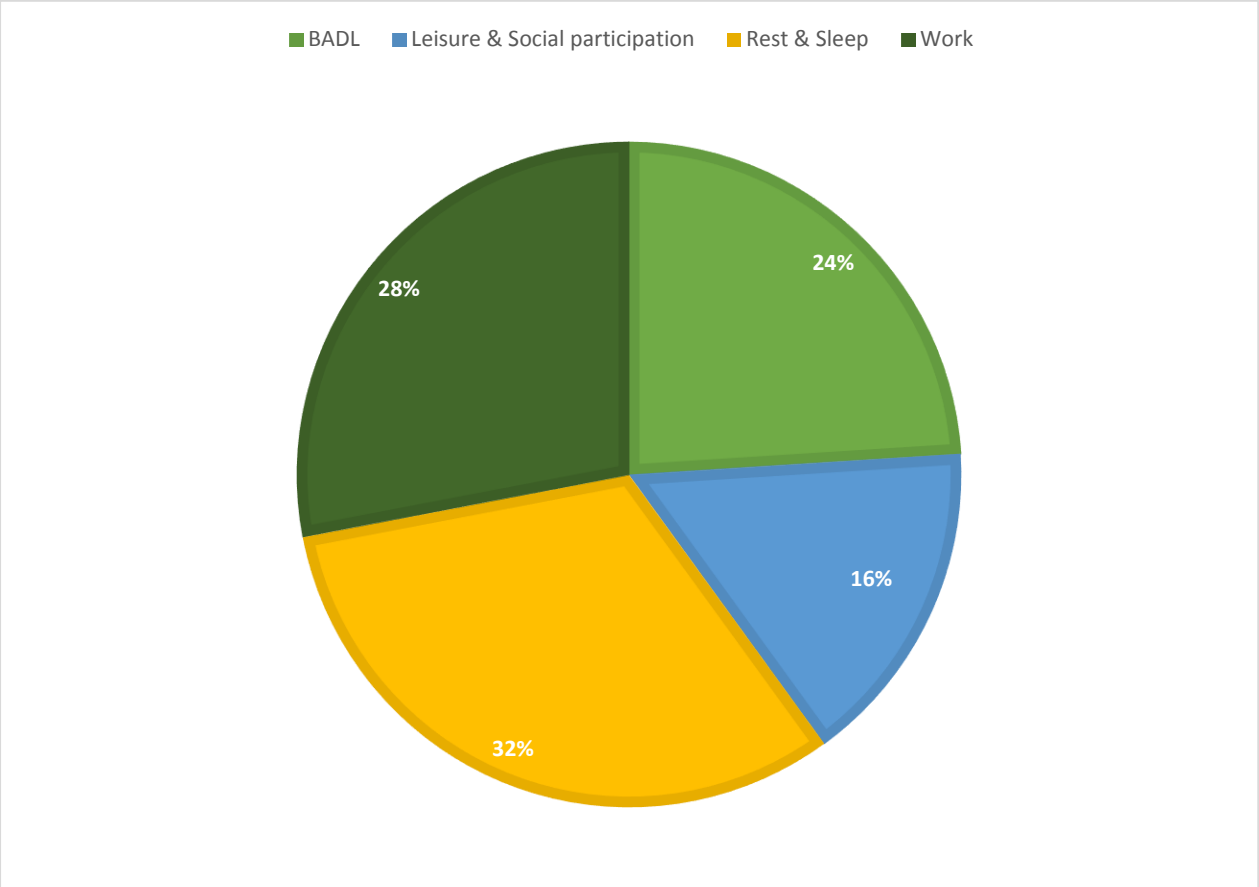


Figure 5 – Content analysis findings of the case of Carmelita Activities Clock.

BADL's included activities of taking medication, showering, feeding and eating, grooming, dressing, oral hygiene and praying which accounted for 24% of time within a typical day out of hospital. Work and productive activities included sewing, cutting fabric, pattern making, visiting the seamstress and administrative tasks such as phone calls and creating quotes, which accounted for 28% of time within a typical day out of hospital. Leisure and social participation activities included watching inspirational videos on you tube and cycling with her friends in the community, which accounted for 16% of time within a typical day out of hospital. Rest and sleep accounted for 32% of time within a typical day out of hospital.